Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEW! 17, 17, per HH, CS/6, 4/16/05, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 20:15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAITO A mem. Un:on If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number 6. Sex Funeral Days 1 ■ M 2 Hours Months 216-20-51189 Usual Residence of Decedent Director 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits show ns 23a or 28a-f show must be notified at 1 ☐Yes 2 ☐ No Director M.D. 10e. Street and Number 10g. Citizen of What Country? U.S.A Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. ral", or items ! 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**0 BlACK þ 3 Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MAKER 24125 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be is marked of ဥ 30h50 N or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health if 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Department of Important: If it any Injury or o once. Arbutus Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specity) 21. Signature of Funeral Service Licensee 0.m] 23a. Bart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** disease or condition resulting in death) days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine bstructure The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 1□ Yes Records. P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1∏ Yes Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 ☑Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 (Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/3/08 AT2438946-H24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union 201 E. University Plany Bultural, MD 21218 Barackm Memorial Hospital 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 5 200 geer 8:00 AM M **Physician** William Midwig Sr. /Medical 4a. Facility Name (If not institution, give street and number)
9258 Goodspring Drive 4c. County of Death 4b. City, Town, or Location of Death Examiner Perry Hall Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Davs | House | Min Date of Birth (69/21/1927 5. Social Security Number 6. Sex Birthplace (State or Foreign PA Country) **Funeral** Months Days 219-22-7631 1.☑-M 2□ F Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits is 1 end 2 should be filed within 72 hours after death with the Marylan is Health and Mental Hygiene.
Item 27 is marked other then "neture!", or Iteme 23a or 28a-f show other traumatic event, The Medical Engineer must be notilised at MD Baltimore Perry Hall 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 9258 Goodspring Drive 21128 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Amed Folds: 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: W 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Caucasian þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Trucking Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Viola Orwig Norman Midwig 19a. Informant's Name/Relationship (Type, Print)
William Midwig Jr./ Sc permit. Pages 1 end 2 sh Department of Health and Importent: If item 27 ie m eny injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 2106 A Park Beach Dr. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition Paper 9 20c. Location - City or Town, Sfate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2008 21. Signature of Funeral Service Licensee M01443 <sup>22</sup>Cremations and Funeral Alternatives Rutter 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARCINOMA TONSILLAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, ourcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Š COFD DEMENTIA 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate hes autopsy performed? 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred Hospital or Attending To the Hospital or Autoria.

Within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40008 Tarshall 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

PARSHALL

APR 0 9 2008

31. Date filed (Month, Day, Year)

Saltimore.

68760

Box

Records,

Vital

ð

Division

32. Registrar's Signature

9105 FRANKLIN SQUARE DR., BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛛 🗎 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Walter Phillip MacKnew, 2008 6:13 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland
5. Social Security Number Greneral Baltmore HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD Days Hours 124M 2 F 213.42.4834 Director 64 Usuat Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo unk unk unk 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? unk unk U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: \ Q ☐ ↓ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) Cotlege (1-4or 5+) Painter Residential 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Walter MacKnew, Sr. Mildred Holland 19a. Informant's Name/Relationship (Type, Rrint), Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 le any Injury or other trai Jessica MacKnew/Daughter 2906 Huntingdon, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State Chesapeake Crem. 04.05.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, MOLY43 21. Signature of Funeral Service Licensee P.A. 8717 Green Pastures Dr. Balto., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner URG 0 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit been signed by the attending physicien and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an cartificate has autopsy performed? res 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowled a death accuracy that time date and also and due to the date(s) and in accuracy as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Labor

State

Registrar

30. N. e and address of person who completed cause of death (Item 23a) (Type, \_int)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR 0

9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Gerrard Lee Megginson

| 2008   150 | 2 | 0 | 0 | 8 | St. 1881 - Will |  | 5 | 0 | 1 |
|------------|---|---|---|---|-----------------|--|---|---|---|
|------------|---|---|---|---|-----------------|--|---|---|---|

|  |                | Registrar  |  |   | ertificat                  | e oi         | Death                     |                 |                     |                | F   | Reg. No.                     |                      |  |
|--|----------------|--|--|---|----------------------------|--------------|---------------------------|-----------------|---------------------|----------------|---|------------------------------|----------------------|--|
| Physicia<br>Nedical Exami  | Month Day Your |  |  |   |                            |              |                           |                 |                     |                |   | 3. Time of Death<br>0920 hrs |                      |  |
| W. T.  |                | 4a. Facility Name (if not institution 400 South Stricker Stricker                                      |  | umber)                                    |                            | 4            | b. City, Tov              |                 | ocation of          |                |   | 4c. Co                       | ounty of E           | Death  |
| Funeral<br>Director  |                | 5. Social Security Number 215-21-4293  | 6. Sex   | 7. Age (In yrs                            | s. last birthd             | lay)<br>Yrs. | If Under<br>Months        |                 | If Under<br>Hours   | 24Hrs.<br>Min. |   |                              | F                    | e). Birthplace (State or or oreign Country MARYLAND                        |
| w any  |                | Usual Residence of Decedent  10a. State  10b. County   |  | 10c. C                                    | ty, Town or                |              | on                        | -               |                     |                | 03/20   | 7/ 1700                      |                      | 10d. Inside City Limits  |
| /aryland<br>28n-f show<br>1 at once.   | ctor           | MARYLAND N/  | A  |   |                            | E            | BALTIN                    |                 |                     |                |   | 10g. Citizen                 | of What              | 1 XXYes 2 No   |
| th the Maryland<br>23n or 28n-f sho  | Director       | 1235 HOLLINS   | ST.  |   |                            |              |                           | 212             | 23                  |                |   | _                            | .S.A                 |  |
| r death wi   | Funeral        |  | arried Armed F   | 2 XX No                                   |                            | If Ye        | es, specify (             | Cuban,          | Mexican, I          |                | Specify Yes or No-<br>o Rican, etc.)  14. Race - Ame<br>White, etc.  Specify:BLAG |                              |                      |  |
| 21215-0036<br>Id be filed within 72 hours after<br>dental Hygiene.<br>narked other than "natural",<br>event, the Medical Examiner  | Ď              | Widowed 4 Div<br>15. Decedent's Education (Spe   | orced If Yes, Give Yes<br>or Dates:<br>cify only highest gra |   | 16a. De                    | cedent       | Yes 2 y                   | cupatio         | n (Give ki          |                |   |                              |                      | ness/Industry  |
| 36<br>thin 72 ho<br>te.<br>than "na<br>edical Ex   | Completed      | Elementary/Secondary (0-12)  | College (  | 1-4 or 5+)                                |                            | J            | ost of working            |                 | OO NOT u            | ise retire     | d)  |                              |                      |  |
| 5-00.5<br>ed withi<br>tygiene.<br>other the  | Com            | 10th grade<br>17. Father's Name (First, Middle,  | Last)  |   | CC                         | ONST         | RUCTI                     |                 | 8.Mother's          | Name (F        | First, Middle   | , Maiden Sui                 | SELF                 |  |
| 21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be             | MAURICE MEGGI  |  |   | 140                        |              | • • • •                   |                 |                     |                | NELSO   |                              |                      |  |
| MD 2<br>nd 2 shoul<br>ulth and M<br>m 27 is m  | ٤              | 19a. Informant's Name/Relations Catherine Page   |  | ther                                      | 400                        | -            |                           |                 |                     |                |   |                              |                      | State, Zip Code)<br>re <u>Md 21227</u>                                     |
| ore, I<br>es 1 and<br>of Healt<br>If item  |                | 20a. Method of Disposition  1 XXBurial 2 Cremation   |  | 20  | b. Place of I              | Disposi      | ition (Name<br>ner place) |                 |                     |                | Date  |                              |                      | ity or Town, State   |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med   |                | 4 Donation 5 Other Spanish   | pecify:  | I I                                       | AT ZIC                     |              | CEMETE                    |                 |                     | 04-0           |   |                              |                      | NE, MARYLAND   |
| Ba<br>pern<br>Temp<br>inju   | (              | parbara CD   | roun   |   |                            | 1  1         | L206 W                    | NO              | RTH A               | AVENI          | UE  |                              |                      | HOME P.A.  |
| Physician<br>/Medical  | 1              | 23a. Part I. Enter the disease, or failure. List only one cause  | on each line.  |   |                            | enter th     | ne mode of                | lying, s        | uch as ca           | rdiac or r     | espiratory a  | rrest, shock,                | or heart             | Approximate Interval<br>Between Onset and<br>Death                         |
| ⁻xaminer   |                | Immediate Cause (Final disease<br>or condition resulting in death)                                     |  | a consequence                             |                            |              |                           |                 |                     |                |   |                              |                      |  |
|  | Jer            | Sequentially list conditions, if any, leading to immediate   |  | a consequence                             | e of):                     |              |                           | _               |                     |                |   |                              |                      |  |
| ed   | Examiner       | cause. Enter Underlying Cause<br>(Disease or injury that initiated<br>events resulting in death). Last | Due to (or as a  | a consequence                             | e of):                     |              |                           |                 |                     |                |   |                              |                      |  |
| 760,<br>cate be executed<br>physician and<br>the burial - transit  | dical          | UNPENDED   | d AMENDED  |   |                            |              |                           |                 |                     |                |   |                              |                      |  |
| ing as a   | - <del>6</del> | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                                     | ne 1 Live  | outcome of pr<br>birth<br>nant at time of | 2                          | =            | tal death                 | 3               | Ectopic             | pregnan        | су  |                              | ate of de            | Day Year   |
| that the death cer<br>ned by the attendi   | Physici        |  | known 9 Unkn   | iown                                      | 3 [                        |              | her (Specif)              |                 |                     |                |   |                              |                      | ·  |
| s, P.O. iries that th signed by  | ð              | Part II. Other significant condit  | contributing t   | to death but no                           | ot resulting i             | in the u     | inderlying ca             | ause gi         | ven in Par          | t I.           |   |                              |                      | Probably 4 Unknown   |
| Division of Vital Records, P.O. Box ( To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for use | Completed      |  |  |   |                            |              |                           |                 |                     | _              |   | opsy<br>formed?              | prid<br>dea          | ere autopsy findings available or to completion of cause of ath?  Yes 2 No |
| tal Rection: The certificate ector, page   | BeC            | 25. Was case referred to medica examiner?  |  |   |                            |              | 26                        |                 | of Death (          | Check or       | nly one)  |                              |                      |  |
| n of Vital Rec<br>ding Physician: The l<br>After this certificate I<br>funeral director, page  | P              | 1 ✓ Yes 2 No<br>27. Manner of Death  |  | Inpatient 2                               | ER/Out                     |              |                           | <u> </u>        |                     |                | Home 5  |                              |                      | Other: Scene   |
| ision of<br>Attending Pl<br>or death.<br>rector: After<br>by the funeral   | Certification: | 1 Natural 5 Pend   | ding<br>stigation FOUNI<br>Apr 3, 2                          |   | 28b. Tir<br>FOUN<br>0914 h | ID:<br>hrs   |                           | I Ye            | vat Work?<br>es 2 ✓ | No S           | ubject sh   |                              |                      |  |
| Divis  | Certific       | 4 Momicide dete  | a not be   | ce of Injury - A<br>Field                 | t home, farr               | n, stree     | et, factory, o            | ffice bu        | ilding, etc         |                | or Town,  | State)                       |                      | or Rural Route Number, City<br>timore, MD                                  |
| Dir<br>Dir<br>To the Hospital o<br>within 24 hours at<br>To the Funeral D  | Medical (      |  | hysician: To the be<br>miner:On the basis<br>and manner:     | of examination                            |                            |              |                           |                 |                     |                |   |                              |                      |  |
|  | Σ              | 29b. Signature and title of certific   | W, n   | N.P                                       |                            |              | - 1                       | icense<br>D.C.N | number              |                |   |                              | te signed<br>1, 2008 | (Month, Day, Year)   |
| _  |                | 30. Name and addres of person<br>Ling Li, MD Assista   | who completed cau<br>int Medical Exa                         |   |                            | Stree        | et, Baltim                | ore, N          | MD 2120             | 01             |   |                              |                      |  |
| St<br>Regis  | ate<br>trar    | 31. Date filed (Month, Day, Year)  | 2008 Z R   | egistrar's Sign                           | ature                      | 1916         | E .                       |                 |                     |                |   |                              |                      |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEW? perFH (878 4/22/08 WS State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMonth Physician Madison 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital 05 eda Date of Birth (Month, Day, Year) 3.30.2008 If Under 1 Year (In yrs. last birthday) Birthpla **Funeral** Days Hours 1 □ M Director idence of Decedent Usual Res 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 Tes 2 □ No **Funeral Director** undal 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1.S.F 21222 roenina Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) nfant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental DIODNE ۵ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6836 Broening Ind Dundalk MD 202 Date 20c. Location - City or Town, S Dionne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or c once. 22. Name and Address of Facility Cremation Services 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Greenmant 21. Signature of Funeral Service Licensee M01363 5151 Baltimore National Pike Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or s a consequence /Medical Examiner treme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed the burlal-transi Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 5 ☐ Other (specify) signed by the aid be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate Yes 2 □ No 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 ☐ Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22511 KottaPalui 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Hospital Drive, Baltimore, MP. 21237 KottaPalli 9000 Franklin 9°2008 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 's Name (First, Middle, Last) Month 2 Physician Y)25 es /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age [In yrs. last birthday, Social Security Number Funeral Days Hours 212-48-667 Usual Residence of Decedent 212-48-Director Mana with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 ehow emb injury or other traumatic event, Ita Madical Examinating the notified at once. 18 Pes 2 No by Funeral Director HIMOr 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces? Yes 2 No Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No imore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: Marine, Charles Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) hemica Elementary/Secondary (0-12) College (1-4or 5+) 20 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maide Be 2 veland Marine 8.8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CWINGS 21. Signature of Funeral Service Licenses Funeral Services Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of Sung, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Brainstem Herniah con Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner massive Intracerebred Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Hypertensive that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus Diabetes 1 Yes 2 No 3 Probably 4 Winknown peen Obesit 24b. Were autopsy findings available prior to completion of cause of death? morbid 24a. Was an has page 2 autopsy 2 No 1 🗌 Yes 2/0 or Attending Physicien: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 □ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March, 31, 2008 D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Baltimore, MD 21230 Aparna Jonnal Good Samaritan

Registrar

State

31. Date filed (Month, Day, Year)

APR 0 9 2008

ORIGINAL

(1234 de )

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4/6/2008 George W. Mallory, Jr. 11:34A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 707 Maiden Choice Lane, 8-106 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5/8/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 213-28-0499 76 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane, 8-106 USA 14. Race 21228 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 51 - 55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Be Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. Postal Worker Fed. Goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of George W. Mallory, Sr. Julia E. Waddey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Cluster / nephew 122 Janelin Drive, Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4/10/2008 Baltimore, Maryland any injury 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or ma consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1-Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours at To the Funeral D XI

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ZU N. 12016

APR 0 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pro 21228 JWCaklvno atroville 32. Paistrar's Signature

1044243

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Miguel Luis Morales April 7, 2008 10:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist @ GBMC Towson 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F California Director Aug. 10, 1959 583-17-8158 48 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Marylan 10a. State 10b. County 28a-f shov iral", or items 23a or 28a-f show Director 1 ☐ Yes 2 XNo Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 315 Roxbury Court 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Puerto Rican White Completed 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)
Public Affairs College (1-4or 5+) Elementary/Secondary (0-12) Information Manager Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Jose Luis Morales ၉ Lucinda (nmn) Laquenta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Martha Morales / Wife 315 Roxbury Court, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ment of h 1 Burial 2 ☐ Cremation 3 Removal from State Mountain Christian Chr. 3-9-08 4 Donation 5 Other (Specify) Joppa, Maryland Fune A Service 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LIOBLASTOMA MULTIFORME MONTHS disease or condition resulting in death) /Medicat We to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Page 1 the burial-transi Physician/Medical Exam resulting in death) Last Due to (or as a consequence of): Box 68760, physician aftending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 Al No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

10+1

State Registrar 29a, Certifier (Check only

29b. Signature and title of certifie

29c. License number D64395

1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

APRIL 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, MD 21204 1 MS0 6565 N CHARLES ST, SUITE 209

31. Date filed (Month Lay, 32. Fegistrar's Signa

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                  | 1 - State of Marylan  | -                      | artment o                             |                     |                    | nd M       |   | iene<br><sub>eg. No:</sub> 00 (         | 3   | 5                                     | 09                   |
|---|------------------|---|------------------------|---------------------------------------|---------------------|--------------------|------------|---|---|---|---------------------------------------|----------------------|
| Physic  | ian              | 1. Decedent's Name (First, Middle, Last)  |                        |                                       |                     |                    |            | Date of Dear     Month                      | Day Y                                   | ear   | Time of                               |                      |
| /Medi<br>Exami  | cal              | Helen Mcknew Spamer Matthews  4a. Facility Name (If not institution, give street and number)  |                        | 4b. City, Tov                         | vn. or Lo           | ocation of         |            | pril  | 6 2008<br>4c. County of                 |   | 25                                    | P "                  |
| LXdIII  | iei              | Broadmead Nursing Home  |                        | Cocke                                 |                     |                    |            |   | Balti                                   |   |                                       |                      |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 1 → 7. Age (In yrs. 1 → M 2 ▼ F 82   | last birthday)<br>Yrs. | If Under 1 Y<br>Months D              |                     | f Under 2<br>Hours | Min.       | 8. Date of Birth<br>(Month, Day,<br>March 3 | Year) 9                                 | Birthplace<br>Country)<br>MD                | (State or                             | r Foreign            |
| land land   |                  | Usual Residence of Decedent           10a. State         10b. County         10c. Cit   | y, Town or Lo          | cation                                |                     |                    |            |   |   | 10d.  | Inside Cit                            | ty Limits            |
| a-fsh   | ctor             | MD Baltimore  | Coc                    | keysvi:                               | 11e                 |                    |            |   |   |   | 1 🗌 Yes                               | 2 No                 |
| vith the  | Funeral Director | 10e. Street and Number  |                        | 10f. Zip Co                           |                     | 000                |            | 1   | 0g. Citizen of Wha                      | at Country?                                 | •                                     |                      |
| eath v  | eral             | 13801 York Rd. T355  11. Marital Status 12. Was Decedent Ever in U  | S. 13.1                | Was Decedent                          |                     | 030                | in? (Spe   | cify Yes or No-                             | USA                                     | American li                                 | Indian.                               |                      |
| perfullible; Mary yial to 212.30000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Evarinar must be notified at ange. | by Fun           | Amed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:  | 1                      | fYes, specify<br>1 □ Yes 2 <b>X</b> □ |                     |                    | Puerto F   | cify Yes or No-<br>Rican, etc.)             | Black,                                  | White, etc.<br>white                        |                                       |                      |
| 72 hor  | eted             | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Deced             | dent's Usual C                        | ccupatio            | on<br>ina most     | of workin  | na l  | 16b. Kind of Busin                      | ness/Indust                                 | try                                   |                      |
| within ne   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  |                        | kind of work of<br>DO NOT use r       | etired)             | g 11700t           | 0. 1101111 |   | T                                       |   |                                       |                      |
| filed v<br>Hygie<br>other t   |                  | 17. Father's Name (First, Middle, Last)   | Teac                   | ner                                   | 18                  | B. Mother          | 's Name    |   | Educatio<br>Maiden Sumame)              | <u>n</u>                                    |                                       |                      |
| uld be<br>Mental<br>rked c  | To Be            | Henry Edward Spamer   |                        |                                       |                     | Emi1               | y Ge       | row Bar                                     | nard                                    |   |                                       |                      |
| d 2 sho d 2 sho th and h  | ŀ                | 19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Lawrence Matthews/son  |                        | •                                     |                     |                    |            |   | is, MD 2                                |   | de)                                   |                      |
| of Heal   |                  | · · · · · · · · · · · · · · · · · · ·   |                        | sition (Name on atory or other        |                     |                    |            |   | 20c. Location - Ci                      |   | State                                 |                      |
| rmit. Pages<br>partment of<br>portant: If it<br>y injury or o   |                  | `4 □Donation 5 □ Other (Specify)  | etro C                 | remato                                | ry                  | 4/                 | 7/08       |   | Catonsvi                                | 11e,  | MD                                    |                      |
| Dermi<br>Depa<br>impo<br>any ir   |                  | 21. Signature of Function Solve Licensele  Micheal J Flagle   | L                      | Name and A<br>emmon I<br>U W. Pa      | Fune<br>adon        | ral<br>ia R        | Home       | of Dul                                      | aney Val                                | ley,  | Inc.                                  |                      |
|   |                  | 23a. Part1. Enter the disease, of publications that caused the deat shock, or heart failure. List only one cause on each line.  | h. Do not ent          | er the mode o                         | f dying, s          | such as c          | ardiac o   | r respiratory arr                           | est,                                    | Inte  | proximate<br>terval Bet<br>nset and E | ween                 |
| Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)   | uence of):             | KE                                    |                     |                    | <u> </u>   |   |   |   |                                       |                      |
| Examiner  |                  | 141/2   | DER                    | TEN                                   | 15/                 | ON                 | /          |   |   |   |                                       |                      |
| tuted d   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | uence ot):             |                                       |                     |                    |            |   |   |   |                                       |                      |
| cate be executed physician and the burial-transit   | cal Exa          | resulting in death) Last Due to (or as a conseq   | uence of):             |                                       |                     |                    |            |   |   |   |                                       |                      |
| g phys  | 0                | d   |                        |                                       |                     |                    |            |   |   |   |                                       |                      |
| The Collas, T.C. BOX 600.<br>The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitution of the pregnant at time | Ideath 3               | Ectopic pregr<br>Other (speci         |                     |                    |            |   | 23d. Date of Month                      |   | y ì                                   | Year                 |
| wrequires that the seen signed by should be detailed  | þ                | Part II. Other significant conditions contributing to death but not res   | sulting in the u       | nderlying caus                        | se given            | in Part I.         |            | 23e. Did to                                 | bacco use comib                         | ute to the ca                               |                                       |                      |
| Physician: The law reconstruction: The law reconstruction that bee all director, page 2 shot  | ompleted         | ATRIAL FIBRI  | LLA                    | TON                                   |                     |                    |            | 24a. Was a autops perform                   | sy prid<br>med? dea                     | re autopsy<br>or to comple<br>ath?<br>Yes 2 | etion of ca                           | available<br>ause of |
| VIICAL<br>Ician: T<br>sertifical<br>ector, p  | BeC              | 25. Was case referred to medical examiner?  |                        |                                       |                     | 6. Place           | Death      | (Check only or                              |   |   |                                       |                      |
| Physic<br>this c  | 2                | Hospital  | ER/Outpatier           |                                       | Other               |                    |            |   | ence 6 Other                            |   |                                       |                      |
| nding Ith.  | tlon             | 1 ■ Natural 5 □ Pending 2 □ Accident investigation (Month, Day Year)  | Injury                 | M 200.                                | Injury at Work?     | s 2 🗆 N            |            | tod. Describe in                            | ow injury occurred                      |   |                                       |                      |
| al or Atters after dead in by the   | ertification:    | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif  |                        | reet, factory, or                     | ffice               |                    | 2          | 28f. Location (S.<br>City or Town           | treet and Number<br>n, State)           | or Rural Ro                                 | oute Num                              | ber,                 |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | edical C         | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knot on the basis of examiner and manner stated.   | owledge, death         | h occurred at t<br>vestigation, in    | he time,<br>my opin | date and           | l place, a | and due to the c                            | ause(s) and mann<br>late and place, and | er as stated<br>d due to the                | d.<br>e cause(s                       | ;)                   |
| To the within To the comp   | Me               | 29b. Signature and title of certifier   | 1,71                   | 29c. L                                | icense n            | number             | 00         | 2   | 29d. Date signed (                      | Month, Day                                  | r, Year)                              |                      |
| 7   |                  | 30. Name and address of person who completed cause of death (Iter   | 1 // Tune              | Print                                 | 1)                  | ) § c              | 27         | 1   | 7///                                    | 201   | ) X                                   |                      |
| 10  |                  | 13801 York Rd Corke   | Sui /                  | 10 M                                  | 0~                  | 210:               | 30         |   |   |   |                                       |                      |
|   | ate              | 31. Date filed (Month, Day, Year) 32 Registrar's Sign   | ature                  | rolls.                                |                     |                    |            |   |   |   |                                       |                      |
| Regist  | ırar             | APR 0 9 2008 Lighten A  | September 1            |                                       |                     |                    |            |   |   |   |                                       |                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:15 MEZZULLO AM APRIL 6 2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Location of Death Town. Examiner nune N/AYear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number vrs. last birthday) 7. Age (II Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days 66 212-40-7106 Director May 7, 1941 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland montai Hygiene. 10c. City, Town or Location 10h. County 10a. State 10d. Inside City Limits of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Crofton 1 ☐ Yes 2XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731 Dryden Way 21114 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zita Madelyn Fick Frank A. Mezzullo 2 permit. Pages 1 and 2 sht.
Department of Health and A.
Important: If item 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reida Mezzullo/wife 21114 Crofton, MD 1731 Dryden Way 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gard Apr. 10,2008 Timonium, Maryland 22. Name and Address of Facility  ${\sf John}_{\sf O}$  .  ${\sf Mitchell}_{\sf IV}$  , 21. Signature of Funeral Service Licenses Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final fa mostate (aucon stance **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the aid be detached for TYPS 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate 1∐ Yes 20 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examinar 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∏ No 2 ER/Outpatient 3 DOA this ဥ 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; of completely filled in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

address of pe

31. Date filed (Month, Day, Year)

BALTIMORE

so) who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year OBERT **Physician** MILLER 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A BALTIMORE HO5 HARBOR Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 👿 M 2 🗆 F Yrs. 199 10 3193 89 03/24/1919 Pennsvlvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Glen Burnie Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 813 Scott Circle 21060 by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miller Miller (unavailable) Dorothy (unavailable) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Step-daughter 813 Scott Circle Glen Burnie, Maryland 21060 Lise' Crowe Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/05/2008 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licena <sup>22. Name and Address of Facility</sup> Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YGARS STIVE HEAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): EUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine TERIAL DISTASE be executed physician and s the burial-trans that initiated events resulting in death) Last Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITIS 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed2 YPERTENSION 2 No certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death Certification: After the Hospital or Attending hin 24 hours after death. the Funeral Director: After Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death
To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESUDO MD

State Registrar

5

DHMH 17 Rev 1/2001

SOUTH HANDLER STREET, BALTIMORE, MARYLAND 2/225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sun

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Richie NIS Duff more pice 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Of 10 19 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign (Country) Months Days Hours Min. 220-36-838 Director an Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 4No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 2 No 1 🗆 Yes þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tmp/oved 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ma Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 D Removal from State Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 1-2008 Carlo Mil my Augless Funeral Sirvice 21. Signature of Funeral Service Licensee loh that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day 5 ☐ Other (specify) ned by the a 9□Unknown 9 Unknown as been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2∏ No 3 Probably 4 I Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page performed? (es 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 No Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 5 🗀 Residence 28a. Date of Injury (Month, Day Year) ner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not determed 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2008

|   |                | For<br>State<br>Registrar  | end 1 ne                         | State of N<br>r Dr. g87  |  |                              |   | ieaith and M<br><i>Death</i>                             | -                                     | giene<br>Reg. No.         | 2008   | 9                       | 513                          |
|---|----------------|--|----------------------------------|--|--|------------------------------|---|--|---------------------------------------|---------------------------|--|-------------------------|------------------------------|
| Physicia  |                | 1. Decedent's Name   | (First, Middle, La               | ist)   |  |                              |   |  | 2. Date of De                         | eath<br>Day               | Year   | 3. Time                 | e of Death                   |
| /Medic  |                | Kort   | az X                             | ea K   | ortaz                                  | Terr                         | one Jones   |  | . 4                                   | 3                         | 2008   | 3 9:3                   | OPM                          |
| Examine   |                | 4a. Facility Name (If  | not institution, give            |  | 1                                      | /                            |   | r Location of Death                                      |                                       | 4c. 0                     | County of Deat                               | h                       |                              |
|   | Ag-            | Unive  | roity                            | of Wla   |  | na                           |   | If Under 24 Hrs.   | 0.0-1(0)                              | 11-                       | L o Fill                                     | h h (O)                 |                              |
| Funeral<br>Director   |                | 5. Social Security No.  n/a  Usual Residence of                    |                                  | Sex 7. A   | .ge ( <b>f</b> n yrs. 1                | Yrs.                         | Months Days   | Hours Min.   | 8. Date of Bir<br>(Month, Da<br>MARCH | ay, Year)                 | 008 g. Birti                                 | inplace (Statuntry)  MD | te or Foreign                |
| land<br>ow  | ŀ              | 10a. State   | 10b. County                      |  | 10c. City                              | , Town or L                  | ocation   |  |                                       |                           |  | 10d. Inside             | e City Limits                |
| death with the Maryland<br>sms 23a or 28a-f show<br>r must be notified at   | 혅              | MD   |                                  |  | BAI                                    | TIMOR                        | Œ   |  |                                       |                           |  | 1 <b>⊠</b> Y            | res 2 □ No                   |
| or 28s  | Director       | 10e. Street and Nun  | nber                             |  |  |                              | 10f. Zip Code   |  |                                       | 10g. Citiz                | en of What Co                                | untry?                  |                              |
| th with with with with with with with wi  |                | 5532 MID   | WOOD AVE                         | APT.   | #1                                     |                              | 21212   |  |                                       |                           | SA   |                         |                              |
| or Ite  | y Funeral      | 11. Marital Status   |                                  | 12. Was Deceden<br>Armed Forces<br>1 ☐ Yes 2 ☑<br>If Yes, Give | ?<br>【No                               | S. 13.                       | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No | lispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)       | - 1                       | 4. Race - Ame<br>Black, White<br>Specify: BL | e, etc.                 | 1                            |
| hours<br>tural",  | ed by          | 3 Widowed  | 4 ∐ Divorced<br>15. Decedent's E | Year or Dates  |  | 16a Dece                     | edent's Usual Occup   | nation   |                                       |                           | d of Business/                               |                         |                              |
| in 72 ho<br>n "natu<br>Aedleal  | Completed      | (Speci   | ify only highest gr              | ade completed)   | .5.)                                   | (Give                        | e kind of work done<br>DO NOT use retired                   | during most of worki                                     | ing                                   | l lob. Kill               | d of business/                               | ridusary                |                              |
| be filed within ntal Hygiene. od other than 'event, the Me  | E              | Elementary/Secon   |                                  | College (1-4o  | (5+)                                   | n/                           | a   |  |                                       | n                         | /a   |                         |                              |
|   | Be C           | 17. Father's Name (  | First, Middle, Las               | 1)   |  |                              |   | 18. Mother's Name  | e (First, Middle                      | , Maiden S                | Surname)                                     | _                       |                              |
| 2 should be and Mental is marked or raumatic eve  | 2              | TERRONE  | JONES, J                         | R.   |  |                              |   | KORTNEY  | NEAL                                  |                           |  |                         |                              |
| 2 should<br>and Mer<br>is marke<br>aumatic  |                | 19a. Informant's Na  | me/Relationship                  | (Type. Print)  |  | 19b. Mail                    | ing Address (Street   | and Number or Rura                                       | al Route Numb                         | er, City or               | Town, State, 2                               | lip Code)               |                              |
| ロナトャ  |                | KORTNEY  |                                  | HER  |  |                              |   | DD AVE   |                                       | _                         |  |                         | 21212                        |
| Pages 1<br>nent of H<br>int: If iter  |                | 20a. Method of Disp<br>1 X Burial 2                                |                                  | Removal from Stat  | 1 ~                                    | lace of Disp<br>emetery, cre | osition (Name of<br>ematory or other plac                   |  | Date                                  | 5712                      | ation - City of DONN                         | Town_State              | T.                           |
| Page transfer transfer transfer transfer jury   |                | 4 ☐ Donation   | 5 Other (Speci                   | fy)  |  |                              | . CARMEL  |  | /2008                                 | BALT                      | IMORE,                                       | MD 2                    | 21224                        |
| permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or other   |                | 21. Signature of Fu  | neral Service Lice               | nsee   | 4.                                     | 2                            | 2. Name and Addre   | WE   |                                       |                           | , JR. E                                      |                         |                              |
| DO = 6 0  | -              | (N)  | sley (                           | Mary   |  | Do not or                    |   | EASTERN  |                                       |                           | MORE, M                                      |                         | 231                          |
|   |                |  |                                  | pplications that saus<br>one cause on each                     | line.                                  | i. Do not er                 | nter the mode or dyli                                       | ng, such as cardiac o                                    | or respiratory a                      | arrest,                   |  | Interval<br>Onset a     | mate<br>Between<br>and Death |
| Physician<br>/Medical   |                | Immediate Cause (I<br>disease or conditior<br>resulting in death)  | rinai<br>1                       | a. Cardi   | respo                                  | ratny                        | far here  | lure months  | <b>U</b>                              |                           |  |                         |                              |
| Examiner  |                |  | - (                              | Due to (or a   | s a connequ                            | Jence of):                   | Ci  | lune   |                                       |                           |  |                         |                              |
| Y.,&  | e.             | Sequentially list con  | nditions,                        | b. Due to (or a  | a consequ                              | uence of):                   | m (a.   | Turce  | -                                     |                           |  |                         |                              |
| ecuted<br>and<br>I-transit  | Examiner       | cause. Enter Under<br>Cause (Disease or i<br>that initiated events | rlying<br>injury                 | inte   | virent                                 | m'cu                         | lar ho  | mmche  | we.                                   |                           |  |                         |                              |
| exec<br>an an<br>rial-tr  |                | resulting in death) L  | ast                              | Due to (or a   | s a consequ                            | uence of):                   |   |  | 8                                     |                           |  |                         |                              |
| ifficate be executed<br>g physician and<br>as the burial-transit  | edical         |  | •                                | d. pren  | ratu,                                  | rity                         |   |  |                                       |                           |  |                         |                              |
| artifica<br>ing ph  |                | IF FEMALE:   |                                  |  |  |                              |   |  |                                       |                           | 3  |                         |                              |
| The law requires that the death certi<br>tte has been signed by the attending<br>age 2 should be detached for use a   | Physician/IV   | 23b. Was decedent<br>in the past 12                                |                                  | 23c. If yes, outcom<br>1 ☐ Live birth                          | 2 ☐ Fetal                              | I death 3                    | □Ectopic pregnanc   | y  |                                       | 2                         | 3d. Date of del<br>Month                     | ivery<br>Day            | Year                         |
| at the dea<br>by the a<br>tached fo   | sic            | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown   |                                  | 4□Pregnant<br>9□Unknown  | at time of de                          | eath 5                       | Other (specify) _   |  |                                       |                           | 03   | 31                      | 2008                         |
| hat the detac   |                |  | icant conditions                 | contributing to death  | but not resu                           | ulting in the                | underlying cause giv  | ven in Part I  | 23e. Did                              | tobacco us                | se contribute to                             |                         |                              |
| ires tha<br>signed  | by             | Into   |                                  | growt  |  | -                            |   |  |                                       |                           |  |                         | □Unknown                     |
| w requir<br>been s  | etec           |  | 1                                | 10.  | 00 1.                                  | <u> </u>                     | ~(10)   |  | Ode Wes                               |                           | Dab Mara si                                  | dana Cadi               | ana augilahla                |
| has<br>has<br>ge 2 s  | Completed by   | Thron  | nbocy                            | topenia  |  |                              |   |  | 24a. Was                              | psy                       | 24b. Were au<br>prior to<br>death?           | completion              | of cause of                  |
|   |                | 25. Was case refer   | ey ta                            | ilure  |  |                              |   |  |                                       | ormed?<br>2 No            | 1 ☐ Yes                                      | 2 <b>X</b> No           |                              |
| sicia<br>certi  | Be             | examiner?  |                                  | Hospital:  | tient 2 🗍                              | EB/Outpotic                  | ent 3 DOA Oth   | 26. Place of Deatl                                       |                                       |                           | Пои <i>(</i> 2                               |                         |                              |
| Phy<br>er this<br>eral d  | <u>د</u>       | 27. Manner of Death  |                                  | 28a. Date of Ir  | jury                                   | 28b. Time                    |   | ry_at Nursing Ho   | me 5 ☐ Hes<br>28d. Describe           |                           |  | ciry)                   |                              |
| ndlng<br>th.<br>; Afte  | 힐              | 1 Natural 2 ☐ Accident   | 5 ☐ Pending investigation        | (Month, E  | ay Year)                               | Injury                       |   | rk?<br> Yes 2∐No   |                                       |                           |  |                         |                              |
| Atter<br>r dea<br>ector<br>by the   | ifica          | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Could not be determined      | 20e. Place of I  | njury - At ho<br>etc. <i>(Specif</i> ) | me, farm, s                  | treet, factory, office                                      |  |                                       |                           | Number or Ri                                 | ural Route l            | Number,                      |
| s afte  | Certification: | 4 [] Homicide  |                                  | building,  | etc. (Specii)                          | "                            |   |  | City of To                            | iwn, State)               |  |                         |                              |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to make the funeral director. | edical (       | 29a. Certifier<br>(Check only<br>one)                              | Certifying P                     | hysician: To the bes<br>miner: On the basis<br>and manner:     | of examina                             | wledge, dea<br>tion and/or i | nth occurred at the ti                                      | me, date and place,<br>opinion, death occur              | and due to the<br>red at the time     | e cause(s)<br>e, date and | and manner as<br>place, and due              | stated.<br>to the cau   | se(s)                        |
| To th<br>withir<br>To th<br>сотр  | Me             | 29b. Signature and   | title of certifier               |  |  |                              | 29c. Licens   | se number  |                                       | 29d. Date                 | signed (Mont                                 | h, Day, Yeε             | ar)                          |
|   |                |  | 1 auch                           | Jew  | ~~                                     | >1                           | 10 17=  | 314  |                                       | an                        | ril 4  | 200                     | 8                            |
| 7   |                |  | ess of person who                | completed cause of   | death (Item                            | 23a) (Type                   | , Print)  | ^-   |                                       | '                         |  | •                       |                              |
| 0   |                | NAOMI  |                                  | ANMD   | 22                                     |                              | Greene  | St Bo  | altim                                 | ove                       | MD S   | 11202                   |                              |
| Stat  |                | 31. Date filed (Mon  |                                  | 4  | strar's Signa                          | ture                         | and of  |  |                                       |                           |  |                         |                              |
| Registra  | ar             | A  | PR 0 9 2                         | 008   1800   | the state of                           | F A                          |   |  |                                       |                           |  |                         |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Thomas Ross Ostrom 6:42 A M 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 Duncannon Drive Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□ F California 83 561-54-1456 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f snov edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Duncannon Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite may Injury or other traumatic event, the Medical Examine one. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Colonel U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Douglas Yelverton Ostrom Sr. Margaret (unk) Ross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Columbia Pike, #618, Arlington, VA 22204 Carolyn Ostrom / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-8-08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Someral Service bicenses 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OVER 8 4EMRS Immediate Cause (Final disease or condition resulting in death) HEART DISEASE Physician /Medical Due to (or as a consequence of): Examiner EKINSON OVER 2 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and the Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC CONSTI OVERSYEARS Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician MALNUTRITION CLER I YEAR Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ POST-TRAUMATIC STRESS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I Director: After to in by the funeral 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29b. Signature and title of certifier

C

29c. License number DØØ 16' 389

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARAO, LI.D. 1716 HARFORD Rd SU 105 FALLSTON MO2047 **'9**" 2008 . Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #788 Per FH 4381 nd/09208 truent of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year tenningtor 2008 :28 AM garet /Medical 4b. City. Town, or Location of Death 4c. County of Death street and number Examiner If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
76 Yrs. 8. Date of Birth 1932 (Month, Day, Year) 3.30. 1930 Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 💢 F 76 Yrs. Director Usual Residence of Decedent 10a, State 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov die a Examiner must be notified at Baltimore 1 Yes 2 □ No Director atonsville 10f. Zip Code 10g. Citizen of What Country? ederick alaa8 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Black Specify by 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Gallege (1-4or 5+) Elementary/Secondary (0-12) permit, Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any Injury or other traumatic event, the I once. pervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Villiam ဥ lara 19b. Mailing Address (Street and Number or Rural Route Number, Informant's Name/Relationship (Type. Print) James R. Kennington. Frederick Rd. Catonsville, DND 21228 Husband 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State lwings Mills and .08 21. Simulature of Funeral Service Balto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vascular Arteriosclevotic Unknown disease or condition resulting in death) OVUNARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached i 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page ; this certificate of Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Yes 2 No 1 Inpatient After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number angenon 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes Kers oun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 9 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11 itchard 9:10 AM John 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Hours 108-16-4810 93 Director 4/4/1915 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, RNG204B 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Attorney Legal os 1 and 2 should be file of Health and Mental Hyu tem 27 is moot 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John M. Pritchard Katherine Richards permit. Pages 1 and 2 sh.
Department of Health and i important; if Item 27 is many injury or 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane E. Bagby / Daughter 8700 Park Heights Avenue, Stevenson, MD 21153 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 又Cremation 3 ☐ Removal from State 4/8/2008 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Anorexia 24a. Was an autopsy perform Congestive 212 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden Choic 21228 Lanc 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 0 9

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend #10b-d Per INF G880 6/23/18 and of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MonthPRIL 2008 CHARLOTTE AGNES QUIGLEY 5:00AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year [ If Under 24 Hrs. ] Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 18.1928 **Funeral** 1 □ M 2XXF Months Days Hours Min. 214~24~6539 Yrs Maryland **Director** 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County item 27 is marked other than "natural" or items 23a or 28a-f sho other traumatic event, it a Medical Examination at norther a Baltimore Maryland XX Yes ... STANO Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 6308 Brook Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes XX No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: White XX Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Secretary Quigley Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked of John J. Peters Madeline Tracey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann P. Hacker (Daughter) 7807 Ardmore Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 4-11-2008 Baltimore, Md/ 21. Signature of Funeral Service Licenses Lassann Funeral Home 7401 Belair Rd. Baltimore, md. 21236 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYELOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) After this certificate has been signed by the attending physician end funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760 e Hospital or Attending P 24 hours after death. e Funeral Director: After t letely filled in by the funera 24 hours a To the within 2

death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 07/08

29c. License number

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

in the past 12 months?

9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Nown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 📉 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

Hospital: 1 Appatient 28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

28d. Describe how injury occurred

29a. Certifier

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PHYSICIAN

RES OO 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMZEHZADE

S. HANOVER STREET

State APR 0 9 2008 Registrar



DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by

Medical

signed by the a d be detached for

cate has been signification can be care has been significant.

director,

funeral

within 24 hours a

Be Certification: To

1 Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

APRIL, 6, 2008

BALTIMURE, MD

21225

31. Date filed (Month, Day, Year)

3001 32 Registrar's Signature

**ORIGINAL** 

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Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Excompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

|                      | 1 = For State Registrar  | Otate of Marylane   |                           | tificate of L   |   |   | eg. No.                                | 0 115                             |  |  |
|----------------------|--|---|---------------------------|---|---|---|--|-----------------------------------|--|--|
| ian                  | 1. Decedent's Name (First, Middle, Last) JOHN B, Rus   | SELL  |                           |   |   | 2. Date of Deat<br>Month                | Day Year                               |                                   |  |  |
| ical<br>ner          | 4a. Facility Name (If not institution, give s RENAISSANCE GAR  5. Social Security Number 6. Sex  | street and number) DEN NURSING  |                           | 4b. City, Town, or SILVER   | SPRIN<br>If Under 24 Hrs.                         | 8. Date of Birth                        | 4c. County of Dea                      | ath OMERY rthplace (State or For  |  |  |
|                      | 227-09-5650  | M 2□F 90  | Yrs.                      | Months Days   | Hours Min.  | (Month, Day,                            |  | (Ouintry)                         |  |  |
| ctor                 | 10a. State 10b. County   |   | Town or Lo                | cation<br><b>Spring</b>   |   |   |  | 10d. Inside City Lir<br>1 ☐ Yes 2 |  |  |
| Funeral Director     | 10e. Street and Number 3148 Gracefield I   | Rd. #209  |                           | 10f. Zip Code<br>20904  | -   | 1                                       | Og. Citizen of What C United S         | -                                 |  |  |
| þ                    | 11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 M2 Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: 1942 - |                           | Was Decedent of His<br>f Yes, specify Cuba<br>I □ Yes 2 2 No                                | spanic Origin? (Spin, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)        | 14. Race - Am<br>Black, Wh<br>Specify: |                                   |  |  |
| Completed            | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation<br>e completed)<br>College (1-4or 5+)  | (Give<br>life. 1<br>Assis | lent's Usual Occupa<br>kind of work done d<br>DO NOT use retired,<br>tant Exec<br>tor of Op | uring most of work<br>utive                       | ing                                     | 16b. Kind of Business Federal          | s/Industry  Governmen             |  |  |
| To Be Co             | 17. Father's Name (First, Middle, Last) Charles Russell  |   | LOT OF OP                 | 18. Mother's Name   | (First, Middle, I<br>Eliza Gre                    | •                                       |  |                                   |  |  |
| -                    | 19a. Informant's Name/Relationship (Type. Print) Pearle M. Russell/Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 3148 Gracefield Rd. #209 Silver Spring   |   |                           |   |   |   |  |                                   |  |  |
| 100                  | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)   |   |                           | sition (Name of<br>natory or other place<br>e Cremato                                       |   | Apr 7 2008                              | 20c. Location - City o                 | or Town, State<br>Le, Marylan     |  |  |
|                      | 21. Signature of Funeral Service License   | ee M0038  | 2 22                      | Name and Addres<br>Rapp Fune<br>933 Gist  |   |   | ervices<br>ng, Marylan                 | d 20910-                          |  |  |
| cal Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   |                           |   |   |   |  |                                   |  |  |
| Physician/Medical    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |   |                           |   |   |   |  |                                   |  |  |
| þ                    | 11VDCDTCLIS IO.1   |   |                           |   |   |   |  |                                   |  |  |
| Completed            |  |   |                           |   |   | 24a. Was a<br>autops<br>perfor<br>1 Yes | sy prior to                            |                                   |  |  |
| Certification: To Be | 25. Was case referred to medical examiner?  1   Yes   2   No   |   |                           |   |   |   |  |                                   |  |  |
|                      | 4 ☐ Homicide determined  29a. Certifier 1 ☐ Certifying Phys  | building, etc. (Specify,  |                           | n occurred at the tin   | ne, date and place,                               | and due to the o                        |  | as stated.                        |  |  |
| Medical              |  | ner: On the basis of examination and manner stated.   |                           |   | pinion, death occur                               | red at the time, o                      |  | ue to the cause(s)                |  |  |
|                      | Mulla Jankh  | WALLED  |                           | DZ  | 4093  |   | APRIL 4                                | 2008                              |  |  |
|                      | 30. Name and address of person who co  | ST M.D. 311   | 23a) (Type,               | Print)<br>ACEF1EL   | DRD:  | SILVER.                                 | SPRING A                               | ND 2090                           |  |  |
| ate<br>trar          | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signat  | ure                       | 100   |   | JINEK.                                  | JINIU I                                | W 2010                            |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician MARY LOU EVANS RICE 2008 1:10 A <u> April</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Towson PICKERSGILL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🂢 F 18. Kentucky 81 Director 407-32-4445 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🗖 No Towson Baltimore County Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 615 Chestnut Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify. Specify: Baltimore, Maryland 21215-0036 þ 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Floral Designer Florist Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Lee Lemon ဂ္ William Laffatt Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 Gothard Road, Lutherville, Maryland 21093 Jeffrey W. Rice\_ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/12/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem\_Park 21. Signalure of Fundral Service Dicensee MITCHELL-WIEDEFELD FUNERAL HOME, INC. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ex Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No certificate 1[ 0 Hospital or Attending Physician: 25. Was case referred to edical examiner? director, 26. Place of Death Check onl one Hospital: Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ie Funeral Director; Af 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (frem 23a) (Type, Print) 30. Name and address of person who

Registrar

State

31. Date filed (Month, Day, Year)

APR 09

2008

32 Registrar's Signature

| 08-02737         |  |
|------------------|--|
| Jack Melvin Ritz |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

amend 18 Per FH G879 5121 08. Jh

| 115 | 2   | 1    |
|-----|-----|------|
|     | 115 | 1152 |

|   | R              | egistrar  | #o Per Fi                              | Certifi                                | cate of                     | Death                    |                     |                           |                          |                             | eg. No.                     |                            | 10 7   |
|---|----------------|---|--|--|-----------------------------|--------------------------|---------------------|---------------------------|--------------------------|-----------------------------|-----------------------------|----------------------------|--|
| Physicia<br>edical Examin   | n/ 1           | 1. Decedent's Name (First, Middle, Last)  TACIC MELVIN RITZ  2. Date of Death Month Day Y April 7, 2008 |  |  |                             |                          |                     |                           |                          |                             | Year                        | 3. Time of Death 1304 hrs  |  |
|   |                | 4a. Facility Name (if not institution 4504 Carlyn Road  | on, give street and nu                 | ımber)                                 | 4                           | b. City, Tow<br>Perry Ha |                     | cation of I               | Death                    |                             | 1                           | unty of Dea                |  |
|   |                |   | 6. Sex                                 | 7. Age (In yrs. last I                 | hirthday)                   | If Under 1               |                     | If Under 2                | 24Hrs. 8                 | . Date of Bi                | rth(MM/DD/\                 | YYY) 9. I                  | Birthplace (State or Foreign                                   |
| Funeral<br>Director   |                | 5. Social Security Number   |  | _                                      |                             | Months                   | Days                | Hours                     | Min.                     | 4-8- <del>2</del>           | .930                        | - 1 '                      | Country)   |
| Director  |                | 217-24-5134   | 1 <b>X</b> M 2 <b>F</b>                | 7.7                                    | Yrs.                        |                          |                     |                           |                          | 4-8-2                       | 000                         | نطب                        | Maryland   |
| <u>\$</u>   |                | Usual Residence of Decedent  10a, State 10b, County   |  | 10c. City, To                          | wn or Location              | on                       |                     |                           |                          |                             |                             |                            | 10d. Inside City Limits  |
| ow any  | - 1            |   | imore                                  |  | ry Hal                      |                          |                     |                           |                          |                             |                             |                            | 1 Yes 2 XNo  |
| Maryland<br>28a-f show<br>d at once.  | 흱              | Maryland Balt   | rmore                                  | rer                                    | ry IIa                      | 10f. Zip Co              | ode                 |                           |                          |                             | 10g. Citizen                | of What C                  | ountry?  |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.  | Director       |   | Daad                                   |  |                             | ء ا                      | 112                 | 0                         |                          | i                           |                             | U.S.                       | Δ  |
| ith the 23a c   |                | 4504 Carlyn   |  | cedent Ever in U.S.                    | 13. Was                     | s Decedent               | of Hispa            | nic Origin                | n? (Speci                | ify Yes or N                | 0- 14.                      |                            | nerican Indian, Black,   |
| ath w<br>items  | Funeral        |   | Armed F                                | orces?                                 | If Ye                       | es, specify (            | Cuban, N            | Mexican, F                | Puerto Rio               | can, etc.)                  |                             | White, etc                 | <b>.</b>   |
| er de   |                | 3 X Widowed 4 Di  | 1 X Yes<br>vorced If Yes, Give Ye      | 2 No                                   | 1                           | Yes 2                    | No                  | specify:                  |                          |                             | Spe                         | ecify:                     | White  |
| irs afi<br>tural'   | 화              | 15. Decedent's Education (Spo   | or Dates:                              |  | 6a. Deceden                 | t's Usual Oc             | cupatio             | n (Give ki                | nd of wor                | k done                      | 16b. Kind                   | of Busine                  | ss/Industry  |
| 2 hot   | eted           | Elementary/Secondary (0-12  | ) College (                            | 1-4 or 5+)                             | during me                   | ost of workin            | ig life. L          | ONOIU                     | se retired               | ')                          |                             |                            |  |
| 036<br>thin ne.   | Compl          | 10  |  |  | Dec                         | ck Cle                   | rk                  |                           |                          |                             |                             |                            | ompany   |
| 5-0036 Iled within 72 Hygiene. Jother than '  | 3              | 17. Father's Name (First, Middle  | e, Last)                               |  |                             |                          | 18                  | .Mother's                 |                          |                             | Maiden Sur                  |                            |  |
| be fill brinked rent,   | Be             |   | vard                                   | Ritz                                   |                             |                          |                     | 1.51                      | No.                      | reen                        |                             | (olb                       | itate, Zip Code)   |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once  | P              | 19a. Informant's Name/Relation  |  |  |                             |                          |                     |                           |                          |                             |                             |                            | 1  |
| MD<br>nd 2 shc<br>alth and<br>am 27 is  | -              | William Ritz 20a. Method of Disposition   | Brother                                | 20h Pla                                | ce of Dispos                | Under                    | of ceme             | a Koa<br>etery,           |                          | Sykes<br>Date               | 20c. Loc                    | ation - Cit                | yland 21784<br>y or Town, State                                |
| or He   | - 1            | 1 X Burial 2 Crematic   | on 3 Removal                           | from State cre                         | matory or oth               | her place)               |                     | İ                         |                          |                             | .                           |                            |  |
| Page ment tant:   |                | 4 Donation 5 Other  | Specify:                               | Par                                    | kwood                       | Cemet<br>Name and A      |                     |                           |                          |                             |                             |                            | e Maryland   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical   |                | 21. Signature of Funeral Service  | Licensee                               |  |                             | 050 Yo                   |                     |                           | nuch                     | OWS                         | on Fui<br>Maryla            | neral                      | Home, Inc.   |
|   |                | 23a. Part I. Enter the disease,   | or complications that                  | caused the death. D                    | o not enter t               | he mode of               | dying, s            | uch as ca                 | rdiac or r               | espiratory a                | rrest, shock,               | or heart                   | Approximate Interval   |
| Physician<br>i al   |                | failure. List only one cause on eath line.  |  |  |                             |                          |                     |                           |                          |                             |                             | Between Onset and<br>Death |  |
| raminer   |                | Immediate Cause (Final diseas<br>or condition resulting in death)                                       |  | a consequence of):                     |                             |                          | _                   |                           |                          |                             |                             |                            |  |
|   |                | Sequentially list conditions,   | b                                      |  |                             |                          |                     |                           |                          |                             |                             |                            |  |
|   | ē              | if any, leading to immediate  |  | a consequence of):                     |                             |                          |                     |                           |                          |                             |                             |                            |  |
|   | Examin         | (Disease or injury that initiated events resulting in death) Last                                       | G.                                     | a consequence of):                     |                             |                          |                     |                           |                          |                             |                             |                            |  |
| 760, ficate be executed g physician and ithe burial - transit   |                | events resulting in doctory associated  | d                                      |  |                             |                          |                     |                           |                          |                             |                             |                            |  |
| e exec  | /Medical       | UNPENDED  | AMENDE                                 | )                                      |                             |                          |                     |                           |                          |                             |                             |                            |  |
| 760, ficate be physiciate purique purique file formation of the formation | Me             | IF FEMALE:  |  | s, outcome of pregna                   |                             |                          | •                   | T                         |                          |                             |                             | Date of de<br>Ionth        | livery Day Year  |
| 68/<br>certific<br>ding   |                | 23b. Was decedent pregnant in<br>past 12 months?  | Des                                    | e birth<br>gnant at time of deat       | L .                         |                          |                     | Ectopic                   | pregnan                  | су                          | "                           | Office .                   | Day Foot   |
| Box 68;<br>death certifithe attending   | Physician      | 1 Yes 2 No 9  |  | nown                                   | 2 0                         | ther (Speci              | · y)                |                           |                          |                             |                             |                            |  |
| O. Be<br>trthe de<br>by the   |                | Part II. Other significant cond   | ditions contributing                   | to death but not res                   | ulting in the               | underlying (             | ause g              | iven in Pa                | rt I.                    | 1.0                         |                             |                            | te to the cause of death?                                      |
| irs that the signed by I be detache   | by             | _   |  |  |                             |                          |                     |                           |                          | 1'                          | Yes 2 ✓                     |                            | Probably 4 Unknown   |
| ds,<br>requir   | etec           |   |  |  |                             |                          |                     |                           |                          | 24a. W                      | as an<br>topsy              | 24b. We<br>pric            | ere autopsy findings available<br>or to completion of cause of |
| e law<br>e has<br>ge 2 sh   | Completed      |   |  |  |                             |                          |                     |                           |                          |                             | rformed?                    |                            | ath?<br>✓ Yes 2 No   |
| ion of Vital Records,<br>tending Physician: The law requir<br>eath.<br>tor: After this certificate has been si<br>the funeral director, page 2 should t   |                | 25. Was case referred to medi   | cal                                    |  |                             |                          | 6.Place             | of Death                  | (Check or                | nly one)                    |                             |                            |  |
| /ital   | Be (           | examiner?   | Hospital:                              | Inpatient 2                            | ER/Outpatier                | nt 3 DO                  | DA                  | Other <sub>4</sub>        | Nursing                  | Home 5                      | Residence                   | ce 6 🗸                     | Other: Scene   |
| of \<br>ing Phy<br>After th   | 1: To          | 27. Manner of Death   | 28a. Da                                | ite of Injury                          | 28b. Time of                | Injury 2                 | 8c. Injur           | y at Work                 |                          | 28d. Descri                 | be how injury               | occurred /                 |  |
| on on ath.  | tion           |   | ending                                 |  | FOUND:<br>1257 hrs          |                          | 1 \                 | res 2 ✔                   | No                       | •                           |                             |                            |  |
| Division<br>tal or Attendi<br>rs after death.   | fica           |   | vestigation 28e. Pl                    | ace of Injury - At hor                 | me, farm, str               | eet, factory,            | office b            | uilding, et               | tc.                      | 28f. Location               | n (Street and               | Number                     | or Rural Route Number, City                                    |
| Division pital or At cours after derest Direct filled in by   | Certification: | 4 Homicide  | etermined (Speci                       | fy) Home                               |                             |                          |                     |                           | _                        |                             | n, State)<br>n Road, Pe     |                            |  |
| Hos<br>24 h<br>Fun  |                | 29a. Certifier 1 Certifying (Check only one) Medical E  | Physician: To the bas                  | est of my knowledges of examination an | e, death occi               | urred at the             | time, da<br>opinion | ate and pla<br>, death oc | ace, and o<br>ccurred at | due to the o<br>the time, d | ause(s) and<br>ate and plac | manner a<br>e, and due     | s stated.<br>e to the cause(s)                                 |
| To the within 2 To the complet  | Medical        |   | and manne                              | er stated.                             |                             |                          | _                   | e number                  |                          |                             |                             |                            | (Month, Day, Year)   |
|   | 2              | 29b. Signature and title of cert  | •                                      |  |                             |                          | O.C.                |                           |                          |                             | April                       | 8, 2008                    | 3  |
|   |                | CHUCK.  | on who completed -                     | auce of death /lta-                    | 232)                        |                          |                     |                           |                          | -                           |                             | -                          |  |
| (XI   |                | 30. Name and address of pers<br>Ana Rubio MD. A   | son who completed c<br>ssistant Medica | ause of death (item.<br>al Examiner 1  | <sup>23a)</sup><br>111 Penn | Street, B                | altimo              | ore, MD                   | 21201                    |                             |                             |                            |  |
| s   | tate           |   | ar) 32,                                | Registrar's Signatur                   |                             | n B                      |                     |                           |                          |                             |                             |                            |  |
| Regis   |                |   | 9 2008                                 | RAPINS AS                              | S. ASON                     | 3.56                     |                     |                           |                          |                             |                             |                            |  |

|                   | <b>Sec.</b>  |                | For<br>State<br>Registrar   | State of M  | aryland                       |   |                         | nt of He<br>te of D         |                               | d Me                    |                             | giene<br>Reg. No.     | 2008   | 1523  |
|-------------------|--|----------------|---|---|-------------------------------|---|-------------------------|-----------------------------|-------------------------------|-------------------------|-----------------------------|-----------------------|--|---|
|                   | - A  |                | Decedent's Name (First, Middle, La  | st)   |                               |   |                         |                             |                               | 2.                      | Date of Dea                 | ath                   |  | 3. Time of Death                                |
| н                 | Physici  |                | William W. Sny  | dow T   |                               |   |                         |                             |                               |                         | Month<br>April              | Day                   | Year<br>2008                                     | 2:00 P <sup>M</sup>                             |
|                   | /Medic<br>Examir   |                | 4a. Facility Name (If not institution, give   | e street and number)  | 1                             |   | 4b. City                | , Town, or l                | ocation of D                  |                         | арттт                       |                       | County of Death                                  |   |
|                   |  |                | Northwest Hospi   | tal Center  | ^                             |   | Rar                     | ndalls                      | stown                         |                         |                             |                       | Baltimo  | re  |
|                   | Funeral  |                | 5. Social Security Number 76. S   | Sex 7. Ag<br>MM 2□F   | ge (In yrs. la                | • | If Unde<br>Months       | r 1 Year<br>Days            | Hours N                       | Hrs. 8.<br>Vin.         | Date of Birt<br>(Month, Da) | h<br>/, Yea <i>r)</i> | 9. Birth<br>Cou                                  | nplace (State or Foreign untry)                 |
|                   | Director   |                | 215-20-2161 Usual Residence of Decedent   | 20.   | 75_                           | Yrs.                                    |                         |                             |                               |                         | 11/9/                       | 32_                   | Mar  | yland   |
|                   | land   |                | 10a. State 10b. County  |   | 10c. City,                    | Town or Lo                              | cation                  |                             |                               |                         |                             |                       |  | 10d. Inside City Limits                         |
|                   | Mary<br>-f sh<br>fied a  | ţ              | MD n/   | a   |                               | ]                                       | Balti                   | imore                       |                               |                         |                             |                       |  | 1 ☐ Yes 2 No                                    |
|                   | r 28a  | Director       | 10e. Street and Number  |   | <u> </u>                      |   | 10f. Zi                 | p Code                      |                               |                         |                             | 10g. Citiz            | zen of What Cou                                  | untry?  |
|                   | th wit<br>23a o<br>ist be  | a              | 205 Fifth Ave.  |   |                               |   |                         | 21225                       | 5                             |                         |                             |                       | USA  |   |
|                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>int, the Medical Examiner must be notified at  | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces                            | ?                             |   | Was Dece<br>If Yes, spe | edent of His<br>edfy Cubar  | panic Origin<br>n, Mexican, P | ? (Specif<br>Puerto Ric | y Yes or No-<br>can, etc.)  | . 1                   | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |   |
| 36                | s afte   | by Fu          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 Mes 2 ☐<br>If Yes, Give<br>Year or Dates                  | No<br>Q53-5                   | .5                                      | 1 ☐ Yes                 | 2No                         | Specify:                      |                         |                             |                       | Specify: Wh                                      | ite   |
| 21215-0036        | hour<br>tural  |                | 15. Decedent's E  |   | . , , , ,                     | 16a. Dece                               | dent's Us               | ual Occupa                  | tion                          | _                       |                             | 16b. Kir              | nd of Business/I                                 |   |
| 75                | in 72<br>n "na<br>Medic  | Completed      | (Specify only highest gr  | ade completed)  | <u> </u>                      | (Give<br>life.                          | kind of w<br>DO NOT i   | ork done du<br>use retired) | uring most of                 | f working               | - i                         |                       |  | ,   |
| 212               | d with<br>giene<br>r tha   | E              | Elementary/Secondary (0-12)   | College (1-4or  | 5+)                           | Co                                      | nstru                   | iction                      | ı                             |                         |                             | Con                   | structi  | on  |
|                   | e file<br>al Hy<br>othe  | Be C           | 17. Father's Name (First, Middle, Last  | )   |                               |   |                         |                             | 18. Mother's                  | Name (F                 | irst, Middle,               | Maiden                | Surname)   |   |
| ylaı              | should be to<br>the Mental I<br>s marked of<br>umatic eve  | 욘              | William W. Snyde  | r, Sr.  |                               |   |                         |                             |                               |                         | erbert                      |                       |  |   |
| Maryland          | 2 sho  |                | 19a. Informant's Name/Relationship  | **  |                               |   | •                       |                             |                               |                         |                             |                       | r Town, State, Z                                 | . ,   |
|                   | l and<br>lealth<br>m 27<br>her tr  | 1 3            | Mrs. Marlene Amla   | nd-Snyder   | on-m                          |   |                         |                             |                               | imor<br>Dat             |                             |                       | d 21225  |   |
| Baltimore,        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.   |                | 1 ☐ Burial 2 Cremation 3 [  | Removal from State  |                               | eighorg<br>merely, de<br>oudon          | natory or<br>Darl       | allier blace                | у .                           | /9/0                    |                             |                       |  | Maryland  |
| Ę                 | it. Pa<br>rtmer<br>rtant:<br>njury   | 1              | 4 Donation 5 Other (Special   |   | 6 11                          |   |                         |                             | ! '                           |                         |                             |                       |  | •   |
| Ba                | permit. Pages : Department of H important: If ite any Injury or ot   | ıs y           | 21. Signature of Funeral Service Lice   | I Can   | <b>大</b>                      | 7 36                                    | 520 V                   | Vilker                      | ıs Ave                        | Ba                      | ltimor                      | e, M                  | neral H<br>aryland                               | ome<br>21229                                    |
| П                 |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. |   |                               |   |                         |                             |                               |                         |                             |                       |  |   |
|                   | Physician  |                | Immediate Cause (Final disease or condition   | a. Liver  | cane                          | er n                                    | utos                    | Later                       |                               |                         |                             |                       |  | Onset and Death                                 |
| 4                 | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as   | a consequ                     | ence of):                               |                         |                             |                               |                         |                             |                       |  |   |
|                   | Examino:   | <u>.</u>       | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as  | a consequ                     | ence of):                               |                         |                             |                               |                         |                             |                       |  |   |
| مند               | ted<br>nsit  | Examiner       | Cause (Disease or injury that initiated events  | Duo to (or un   | o a oonsequ                   | crioc oi).                              |                         |                             |                               |                         |                             |                       | - 4  |   |
| I                 | execu<br>and<br>al-tra   | Xar            | that initiated events<br>resulting in death) Last   | C. Due to (or as  | a consequ                     | ence of):                               |                         |                             |                               |                         |                             |                       |  |   |
| 8760              | ficate be executed<br>physician and<br>s the burial-transit  | dical          | (   | _d  |                               |   |                         |                             |                               |                         |                             |                       |  |   |
| Θ                 | tificat<br>ig phy<br>as th   | edi            |   |   |                               |   |                         |                             |                               |                         |                             |                       |  |   |
| Вох               | The law requires that the death certific thas been signed by the attending prage 2 should be detached for use as   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome<br>1 ☐ Live birth                      |                               |   | Ectonic                 | pregnancy                   |                               |                         |                             | 2                     | 23d. Date of deli                                |   |
|                   | ne dea<br>the att  | sicia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnant a  |                               |   | Other (s                |                             | -                             |                         |                             |                       | Month  | Day Year  |
| P.0               | that the deed by the detached  | Phy            | 9 Unknown   |   |                               | M: ( Al                                 | and and other an        |                             | - i- D1                       |                         | 00- Did 6                   |                       |  | Also serves of death 2                          |
|                   | ires tha<br>signed<br>d be det   |                | Part II. Other significant conditions   | contributing to death i                                     | out not resu                  | iting in the u                          | ndenying                | cause give                  | II SI FAILI.                  |                         | 23e. Did (                  | ,                     | Se contribute to                                 | the cause of death?                             |
| 0.0               | w requir<br>been si<br>should  | Completed by   | Type It DIV.  |   |                               |   |                         |                             |                               | _                       |                             |                       |  |   |
| 360               | e law<br>has b   | du             |   | <del> </del>  |                               |   |                         |                             |                               | _                       | 24a. Was<br>autor           | an<br>osy<br>ormed?   | 24b. Were au<br>prior to death?                  | topsy findings available completion of cause of |
| a                 |  |                |   |   |                               |   |                         |                             |                               |                         | 1□ Yes                      | 2 No                  | 1 ☐ Yes  | 2 No  |
| or Vital Records, | Physician: The law<br>this certificate has b<br>ral director, page 2 s   | Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 📉 No  | Hospital:   |                               | -5/0.4                                  |                         | Othe                        | 26. Place of                  |                         |                             |                       |  |   |
| ō                 | > .º 0   | 5              | 1 Yes 2 No<br>27. Manner of Death   | 28a. Date of Inj  | ury                           | ER/Outpatier<br>28b. Time o             |                         | 28c. Injury<br>Work         | 4 🗀 INUISI                    |                         | d. Describe I               |                       | Other (Spector)                                  | city) Injust Itusp                              |
| lon               | Attending r death. ector: After by the fune  | tio            | 1 Avatural 5 ☐ Pending investigation  | ( <i>Month, D</i> i   | ay Year)                      | Injury                                  | М                       |                             | ?<br>′es 2∐No                 |                         |                             |                       |  |   |
| Division          | I or Attendi<br>after death.<br>Director: A<br>d in by the fu  | ijica          | 3 ☐ Suicide 6 ☐ Could not be determined   | Zoe. Flace of II  | jury - At hor<br>tc. (Specify | me, farm, sti                           | reet, facto             | ry, office                  |                               | 28                      | Location (S                 | Street and            | d Number or Ru                                   | ıral Route Number,                              |
| Ö                 | s afte   | Certification: | 4 Hornidae  | building, e   | no. (Opecny)                  | /                                       |                         |                             |                               | 3                       | Only or rol                 | vii, Otate,           | /  |   |
|                   | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Medical (      |   | hysician: To the bes<br>miner: On the basis<br>and manner s | of examinat                   |   |                         |                             |                               |                         |                             |                       |  |   |
|                   | Fo the vithin Fo the complex c | Me             | 29b. Signature and title of certifier   |   |                               |   | 2                       | 9c. License                 | number                        |                         |                             | 29d. Dat              | e signed (Montl                                  |   |
|                   |  |                | Erual D. Hoc  | Herms.  |                               |   |                         | A2                          | 8628                          |                         |                             | 0                     | pril   | 6,2003  |
|                   | 111  |                | 30. Name and address of person who  |   | death (Item                   | 23a) (Type,                             | Print)                  | -                           | 8625                          |                         |                             |                       |  |   |
| _                 | HJ.  |                | Carol G. Homer,   | 133 N. Br   | idge S                        | 7, 81                                   | Kton                    | , me                        | ). 219                        | 2/                      |                             |                       |  |   |
|                   | Sta  |                | 31. Date filed (Month, Day, Year) APR 0 9 2   | 008 324 Regist  | trar's Signat                 | ure                                     | MARKE                   | ,                           | ). 219                        |                         |                             |                       |  |   |
|                   | Regist   | dľ             | 11111000  | Walter said   |                               | The same                                |                         |                             |                               |                         |                             |                       |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) STILLWELL :30 A M **Physician** CLIFTON 2008 APRIL 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 03/07/1927 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2 □ F New Jersey Director 151-14-6791 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No West Deptford Gloucester NJ Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 08096 1164 Ford Avenue Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Maryland 21215-0036 WWII ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Freight Co Dock Worker ith and Mental Hygie 27 Is marked other I r traumatic event, th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Elmira Carey John W. Stillwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 Is any Injury or other trau 1164 Ford Avenue, West Deptford, NJ 08096 Joan Stillwell, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/12/2008 Harleigh Crematory Camden, New Jersey 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ellis-Stiefel Funeral Home 21. Signature of Funeral Service Licensee M01113 301 Highland Avenue, Westville, NJ 08093 Mulos .Tjanwa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia 14 2 aus **Physician** /Medical Due to (or as a consequence of): **Examiner** 1 year ancratic cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the ceath carificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Exam Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. signed by the d be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes 2 No 2 After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 | Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death I Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 MD APRIL, 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mansland 21287 Julia Bearer 600 North Wolf Street 31. Date filed (Month, Day, Year) APR 0 9 2008 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JAS Carl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner XI + (MORE 5 cm 61 8. Date of Birth (Month, Day, Year)
Feb. 12, 1926 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1₩ M 2□ F 212-20-8344 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at MD Baltimore Baltimore 1 □Yes 2 XNo Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5521 Lanham Way 21206 USA 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or items 233 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☑XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Railroad traumatic event, the 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Shiflet Irene Hadley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any Injury or other traun once. Angeline Shiflet /wife 5521 Lanham Way Baltimore MD 21206 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Gardens of Faith 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/08 Rossville MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that dauged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and I for use as the burial-iransit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 2 □ No Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Flart I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has 1□ Yes 2 **1**No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

APR 0 9 2008

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02562 State of Maryland / Department of Health and Mental Hygiene Lamar Skinner 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Deat Decedent's Name (First, Middle,Last) Physician/ Month Day March 31, 2008 2152 hrs Medical Examiner amonCity, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Director Country) 215-25-1662 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location any 1 Lyes 2 No MOVE with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Number a (a) Funeral Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death w Armed Forces? 1 Never Married 2 Yes 2 1 10 Specify: Give Yea Yes 2 LHO specify: 3 Widowed Divorced 2 16b. Kind of Business/Indus 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 1 Moom Representative Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than Baltimore, MD 21215-0036 me (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be skinner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Baltimore MDSISIS Fedora 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 ment . Donation 5 Other Specify Signature of Funeral Service Lice 22. Name and Address of Facility roome Approximate Interval 23a. Part I. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical Between Onset and failure. List only one cause on each line Death a. Gunshot wounds (2) of left shoulder and torso Immediate Cause (Final disease *kaminer* or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical X AMENDED 16a per fh g8784-9-08 vt signed by the attending physician be detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death nast 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medica director, Be examiner? Hospital: Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot Mar 31, 2008 Natural 2114 hrs Yes 2 V No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2400 E Hoffman Street, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 1, 2008 Inn O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD Assistant Medical Examiner Registrar's Signature 31. Date filed (Month Dan Year) State Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible:

| lyan A. Spencer  | 1_ 6           | State of Maryland / Department of Health and Mental Hygic   | erie<br>Reg. N   | In 20                                   | 00 1152  |
|--|----------------|---|------------------|---|--|
| Physician/   | Red            | gistrar 2. Decedent's Name (First, Middle,Last)   | ate of Death     | v Year                                  | 3. Time of Death<br>0108 hrs                   |
| Medical Examine  |                | Rugo A. Sponcor   | pril 6, 2008     | 4c. County of Dea                       |  |
| 61.  | 4a             | 1. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Westminster  |                  | Carroll                                 |  |
| Emperal Control  | 5              | Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8.   | Date of Birth (  | MM/DD/YYYY) 9. B                        | sirthplace (State or                           |
| Funeral<br>Director  | 1              | 83-72-0107 1×M 2 F 27 Yrs. Months Days Hours Min.   | 10/24/           | 1980                                    | country) PA.                                   |
|  | U              | sual Residence of Decedent  |                  |   | 10d. Inside City Limits                        |
| ∗ any  | 10             | Da. State 10b. County 10c. City, Town or Location   |                  |   | 1 res 2 No                                     |
| -f shov  | <u> </u>       | De, Street and Number 10f. Zip Code   | 10g.             | Citizen of What Co                      | ountry?  |
| the Maryland a or 28a-f sh   |                | 2002 Rutald Dood 21207  |                  | USI                                     | 4  |
| s 23a e notif  |                | 12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specifity Specify Cuban, Mexican, Puerto Ric   | fy Yes or No-    | 14. Race - Am<br>White, etc             | erican Indian, Black,                          |
| r death with or items 23 must be no  |                | Never Married 2 Married 1 Yes 2 No  | ,                | Specify:                                | Rlack  |
| s after on miner n   | . اح           | Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work |                  | 6b. Kind of Busines                     | ss/Industry                                    |
| hours<br>matur<br>Exam   |                | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)   | )                | 0 1                                     |  |
| 136<br>Ihin 72<br>Ie.<br>than  | Completed      | 124h Corporate Train  | er 1             | Care F                                  | TIST_  |
| 5-0036 lled within 7 Hygiene. I other that   |                | 7. Father's Name (First, Middle, Last)  | Prat             |   |  |
| be fi  | å L            | 9a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Run   |                  | er, City or Town, St                    | ate, Zip Code)                                 |
| MD 2 d 2 shoul Ith and M n 27 is m aumatic   | 2 3            | Stoppanie, Sporcer 3802 Butield   | Rd,              | Balton                                  | MD 2/207                                       |
| ore, MC<br>is 1 and 2 si<br>of Health ar<br>If item 27   | - 1            | 20a. Method of Disposition 20b. Place of Disposition (Name of carnetery, crematory or other place)  | Date             | 20c. Location - City                    | or rown, State                                 |
| mor<br>Pages  <br>ent of  <br>nt: If   |                | 1 Burial 2 Cremation 3 Removal from State Crematory of Other Specify:   | 9/2003           | 1-301 time                              | ore, MU  |
| Baltimore<br>bemit. Pages 1:<br>Department of H<br>Important: If it<br>injury or other:  | 1              | 21. Signature of Funeral Service Licensee   | Frence           | ealer                                   | 1212   |
| <b>W</b> 80 # #  |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or n   | espiratory arres | st, shock, or heart                     | Approximate Interval Between Onset and         |
| Physician /Medical   | - 1            | failure. List only one cause on each line.  |                  |   | Death  |
| aminer   |                | Immediate Cause (Final disease or condition resulting in death)  a. <u>Diphenhydramine Intoxication</u> Due to (or as a consequence of):                                      |                  |   |  |
|  |                | Sequentially list conditions, b   |                  |   |  |
|  | ₽.             | if any, leading to immediate cause. Enter Underlying Cause  |                  |   |  |
| 1 77 / 75  | хап            | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |                  |   |  |
|  |                | d.    X UNPENDED   AMENDED   23a,27,28a-f per ME g878 4/10/08 amh   |                  |   |  |
| sici be  | ledical        | IF FEMALE: 23c. If yes, outcome of pregnancy  |                  | 23d. Date of de                         |  |
| Box 6876(<br>e death certificate<br>the attending phy<br>ed for use as the b   | sician/M       | 23b. Was decedent pregnant in the a live birth 2 Fetal death 3 Ectopic pregnan  | icy              | Month                                   | Day Year                                       |
| ox 6 eath ce attend for use  | sici           | 1 Yes 2 No 9 Unknown 9 Unknown  |                  |   |  |
| rthe de ached i  | 된              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                  |   | te to the cause of death?  Probably 4  Unknown |
| P.O.   | a p            |   | 24a. Was         |   | ere autopsy findings available                 |
| rds, requir  | Completed      |   | autop            | sy pric                                 | or to completion of cause of ath?              |
| eco<br>he law<br>ate has   | mo             |   | 1 Yes            |   | Yes 2 No                                       |
| al R   | Be C           | 25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 FR/Outnatient 3 DOA Other Nursing  |                  | Residence 6                             | Other: Scene                                   |
| of Vital Records, ng Physician: The law require Mher this certificate has been signeral director, page 2 should h  | 임              | 1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Transfer of Mork?  |                  | how injury occurred                     |  |
| n of<br>ding F   |                | (Month, Day, Year)  | Overdose         | of medicat                              | ion  |
| Division<br>tal or Attendi<br>us after death.  | icati          | 2 Accident Investigation IIId 47 07 00 IIId 12 12 13 14 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16  | 28f Location /   | Street and Number                       | or Rural Route Number, City                    |
| Diviral or us after Illed in   | Certification: |   |                  | state)400 N Ce<br>ter, MD               |  |
| Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and   | due to the cau   | se(s) and manner a<br>and place, and du | es stated.<br>e to the cause(s)                |
| To the vithin To the comple  | edical         | and mainler stated.   |                  | 29d. Date signe                         | d (Month, Day, Year)                           |
|  | ž              | 29b. Signature and title of certifier  O.C.M.E.   |                  | April 6, 200                            | 8  |
|  |                | Carol Halla   |                  |   |  |
| 10 of put  |                | 30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120                        | 1                |   |  |
|  | tate           | 31. Date filed (Month, Day, Year) 32 Registrar's Signature  |                  |   |  |
| Regis  |                | A D D D D D D D D D D D D D D D D D D D   |                  |   |  |

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Sivertsen, Sr. acce -dward 6 illiam /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) **Examiner** bper Chescipeake Medical 7. Age (In yrs. last b Harford County Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □M 2 □ F 4.4.1928 1610-06-801 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No ns 23a or 28a-f sh must be notified Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 731 Old Joppa Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner once. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Architect Architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sivertsen xrothv umdand ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8875 SW Oak lane Portland, Oh 97223
e of Disposition (Name of Date 20c. Location - City or Town, State william Sivertsen, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Termation Pages 1 3 ☐Removal from State mount 3/19/2008 Baltimore, M1
22. Name and Address of Facility Cremation Services Greenmount 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SISI Baltimore National Dike Baltimore Mil 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician photopathi /Medical r as a consequence of): Due to ( Examiner CICKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed the burial-tras Due to (or as a consequence of) signed by the attending physician at the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1☐ Yes or Attending Physician: 26. Place of Death Check onl one director. 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death, after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (*Month*, *Day*, *Year*) 29c. License number 29b. Signature and title of portifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLAUDIA KNOWEN, 1308BUS/NESCO

State Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2008



1308 BUSINESS CENTER WAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:15PM tPR1 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner HOSPITAL BALTIMOR HAR BOR If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 11/21/1921 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 203-05-6473 1 M 2 □ F 86 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ral", or items 23a or 28a-f shor Examiner must be notified at 1 Yes 2 No Maryland Director Baltimore Landsdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Mental Examiner must be not 3239 Kessler Road 21227 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Construction Home Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Sakalas ပ Teresa DoBony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Sakalas / Son 812 St. Anne Drive Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If It any injury or o 1 ■ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VC 4/9/08 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Facility
Hubbard Funeral Home, 21. Signature of Funeral Service Licensee Mak T23 Inc. 4107 Wilkens Avenue Baltimore, 21220 Approxima e Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Encephalopathy Anoxic 3 day 1 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse quence of: Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ast IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) leen signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has I 24a. Was an autopsy performe 2 No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. after death 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

SXI

Registrar

State

30. Name and address of perso

Stre8t Signature

ho completed cause of death (Item 23a) (Type, Print)

225, Baltmorn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Patricia Grace Smallwood 2008 7:30 AM 4, April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2 KF Maryland Director 64 Jan. 31, 1944 214-46-8555 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2815 Belcamp Road 21015 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White M000/5093 (6 4/4 )
■ Baltimore, Maryland 21215-003 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Lane Doss Alma Mae Blevins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley E. Smallwood / Husband 2815 Belcamp Road, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Zion UMC Cemetery 4-7-08 Bel Air, Maryland 21. Signatur of Puneral Auro Lice 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chron disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (of as a consequence of): Examiner and burial-transit Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9☐Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy inhete Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and attle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50040

10

State Registrar

1308 BUSIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

unouen

OS BUSINESS CENTER WAY, SUITE 102, EDGE WOOD, MDZIO40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] § Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:10 AM **Physician** APRIL Doris Mable Smith 05 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ST AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, June 9, 1930) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 XXF 220-20-4938 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Baltimore 1 √Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 2908 Culver Road Funera 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 222 No If Yes, Give Year or Dates: 12 Never Married 2 Married Black 1 ☐ Yes 2. 1 No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore Public Schools teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Smith Fred Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 509 Coverty Road; Baltimore, Maryland 21229 Doris Clay / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 04/11/2008 Arbutus Memorial Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STROKE > 2 weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed RENAL FAILURE attending physician and for use as the burial-tra Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an performed spital or Attending Physician: Thours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05,2005 P21800 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

APR 09 2008



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|              |  |                  | _ For   | State of Maryland / Department of Health a   | and Mental Hygiene  |
|--------------|--|------------------|---|--|---|
|              |  |                  | 1 - State<br>Registrar  | Certificate of Death   | Reg. No.2 008 11532   |
|              | Physic<br>/Medi  |                  | 1. Decedent's Name (First, Middle, La<br>ELIJAH   | THOMPSON   | 2. Date of Death Month Pay Year  7 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9  |
|              | Examir   |                  | 4a. Facility Name (If not institution, gi   | a street and number) Center Bolty, Town, or Location o   | 10 LE Sounty of Death.  10 LE Spiltim UNX   |
| institution. | Funeral<br>Director  |                  | 249-52-4816   | Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Yrs. Months Days Hours   | 24 Hrs. 8. Date of Birth Min. Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. (C                                |
|              | aryland<br>show<br>dat   | Ļ                | Usual Residence of Decedent  10a. State  10b. County  | 10c. City, Town or Location  | 10d. Inside City Limits 1 □ Ves 2 □ No  |
|              | th the Ma<br>or 28a-f  | Funeral Director | 10e. Street and Number  | 101. Zip Code  | 10g. Citizen of What Country?   |
|              | ms 23a<br>must b   | Jeral I          | 4204 P. 1 G. R. 11. Marital Status  | 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Programmes 13. Was Decedent Orig |   |
| 9800         | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>thet, the Me-Acal Examiner must be notified at | þ                | 1 Never Married 2 Married<br>3 Widowed 4 Divorced   | Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  If Yes, specify Cuban, Mexican  1 ☐ Yes 2 ☐ Specify:  | Puerto Rican, etc.)  Black, White, etc.  Specify: B/ACK   |
| 215-0036     | d 2 should be filed within 72 hc<br>th and Mental Hygiene.<br>7 Is marked other than "natu<br>traumatic event, the Me fical  | Completed        | 15. Decedent's E<br>(Specify only highest gi<br>Elementary/Secondary (0-12)   | (Give kind of work done during most life. DO NOT use retired)  | of working  |
| 1d 21        | should be filed withir od Mental Hygiene. marked other than marlic event, the Me   | Be Cor           | 17. Father's Name (First, Middle, Las   | NONE LABOR 18. Mother  | 's Name (First, Middle, Maiden Surname)   |
| Maryland     | should be<br>ind Mental<br>marked o  | 인                |   | oson Lu  | A CROWell   |
|              | 1 an<br>Heal<br>em 2<br>ther   |                  | 19a. Informati's Name/Relationship  ALISE MAY  20a. Method of Disposition   | 196. Mailing Address (Street and Number 4 8 6 4 Pi 196.  20b. Place of Disposition (Name of  | r or Rural Route Number, City or Town, State, Zip Code)  R. M. R. G. BA/TIMORA 13  Date   20c. Location - City or Town, State |
| Baltimore    | Page<br>nent o<br>ant: If<br>ary or  |                  | 1 Burial 2 □ Cremation 3 [<br>4 □ Donation 5 □ Other (Speci   | Removal from State cemetery, crematory or other place)  [Yellow State cemetery, crematory or other place)  [Yellow State cemetery, crematory or other place)   | April 9, 2008 BA Ito my   |
| Bal          | permit. Pa<br>Departmen<br>Important:<br>any Injury once.  |                  | 21. Signature of Funeral Service Lice   | nsee 22. Name and Address of Facility  | nenal Home 212/3  |
| 1            | Physician  |                  | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition     | oplications that caused the death. Do not enter the mode of dying, such as one cause on each line.   | Approximate Interval Between Onset and Death  |
|              | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a consequence of):   | 6 days  |
| /            | uted<br>J<br>ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to Write a consequence of):  | Williams & document UNKERGON  |
| 760,         | ate be executed<br>hysician and<br>he burial-transit   | cal Exa          | resulting in death) Last  | Due to (or as a consequence of):   |   |
|              | ertificate<br>ing phy<br>e es the  |                  | IF FEMALE:  | 0.   |   |
| .O. Bo       | The law requires that the death certifica<br>te has been signed by the attending phy<br>page 2 should be detached for use es th                                      | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  | 23c. If yes, outcome pf pregnancy  1   | 23d. Date of delivery  Month Day Year   |
| Js, P.       | uires that the de:<br>signed by the a:<br>Id be detached f   | by               | Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  12 Yes 2 No 3 Probably 4 Unknown                                      |
| Records,     | w requir<br>been si<br>should  | leted            |   |  | 24a. Was an 24b. Were autopsy findings available  |
| tal Re       |  | Completed        | 25. Was case referred to medical  |  | autopsy performed? performed? death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No   |
| or Vital     | S  | To Be            | examiner?   | Hospital:  | of Death (Check only one) sing Home 5 ☐ Residence 6 ☐ Other (Specify)   |
|              | ffel   |                  | 27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at Work?   | 28d. Describe how injury occurred   |
| Division     | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Certification:   | 3 Suicide 6 Could not be 4 Homicide determined  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)   |
|              | ne Hospit<br>n 24 hour<br>ne Funera<br>netely fille  | Medical C        | 29a. Certifier (Check only one)  Check only one)  Certifying P  Certifying P  | nysician: To the best of my knowledge, death occurred at the time, date and miner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.  | d place, and due to the cause(s) and manner as stated. th occurred at the time, date and place, and due to the cause(s)       |
|              | Vithi<br>To ti   | ž                | 29b. Signature and title of certifier   | 29c. License number  | 29d. Date signed (Month, Day, Year)   |
|              | 4  |                  | 30 Name and address of person who   | completed cause of death (Item 23a) (Type, Print)  | 56 MAN -4, NOX  |
|              | Sta  | te               | 31. Date filed (Month, Day, Year)   | JA WM MA 30157 PAUL P  | 36 April 4, 2008<br>C BALTIMONE MIN<br>21205  |
|              | Registr  |                  | APR 0 9 20  | 08 Klein St. Spark   |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** ori 28 E \*/Medical Facility Name (If not institution, give street and number Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 69-02-2 9. Birthplace (State or Foreign Country) (In yrs. last birthday) Social Security Nu **Funeral** 1196 Min Days 1 M 2 F 216-28-Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at MD 1 Yes 2 No Ltimore **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Franklin St USA #1508 21201 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 is marked other than "natule traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) )omestic OUSCKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tibbs limbers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C+. Balto Department of Health a Important: If Item 27 is any Injury or other trau once. Selwin Md-21237 225 hinda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Ralto Md. -12-08 Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
519 Battimore Wat! Pike Bal 21. Signature of Funeral Service Licensee Balto . Ud - 21229 Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician; The law requires that the death certificate be executed NemBA Completed by Physician/Medical Exami Division or Vital Records, P.O. Box 68760, that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should t 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1☐ Yes 2 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ٩ this funeral 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: : After (Month, Day 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes 2 No death. ours after death.

neral Director: A
filled in by the fu 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address

31. Date filed (Month, Day, Year)

APR 0 9 2008

JULIA

AUL PC BALT

of person who completed cause of death (Item 23a) (Type, Print)

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician April 5, 2008 Lucille E. Terry 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Stayman Court Apt. G Catonsville Baltimore County If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth **Funeral** Days Hours Months 1 M 2 214-22-9761 81 2-09-1927 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes ¾XNo Maryland | Director Baltimore County Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 1 Stayman Court Apt. G 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes **¾**▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3€Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Area ges 1 and 2 should be filed within t of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Convention & Visitor Association Volunteer Coordinator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Whitmer Mildred Naylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Timian Daughter 4609 Ridge Avenue Halethorpe, Maryland 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State permit. Page Department o Important: If injury or Metro Crematory 4 Donation 5 Other (Specify) 4/12/2008 Catonsville, MD 21. Signature of uneral S 22. Name and Address of Facility Burgee—Henss—Seitz Funeral Home, 3631 Falls Road Baltimore, Mar any 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pronory /Medical Due to (or as a conse ce of): Examiner erebrovasc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de a conseguismos of). Examiner and Due to (or as a consequence of) burial-1 Box 68760, physician Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 12 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform page death? 1 ☐ Yes certificate 2 🗆 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes ဥ 1 Inpatient 2 □ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending Natural (Month. Day Year) Injury 5 Pending 1 ∏ Yes 2 ∏ No investigation death. Director: / 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title 29d. Date signed (Month, Day, Year) 29b. 0032388 800

10

State Registrar 31. Date filed (Month, Day, Year)

APR 0 9 2008

DAVID

M WHEELER M.D.
Jonth, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 7108 COLLINGWOOD CT, ELKRIDGE MD 21075
strars Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Рм April Frank Herbert Thatcher 2008 1:20 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville, Maryland Baltimore 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. 1 M M 2 □ F 89 Yrs 302-05-2262 Director May 25. 1918 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD **Funeral Director** Baltimore Catonsville 10e. Street and Number Renaissance Gardens #123 S 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane **USA** 21228 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Forces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Greater Baltimore YMCA Elementary/Secondary (0-12) College (1-4or 5+) 12 General Executive 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earle G. Thatcher Emma Turner f item 27 is marked r other traumatic e ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Carney 6971 Pindell School Rd., Fulton, MD 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If Ite any Injury or ot Hilltop Service 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State... 04/08/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Corporation 21. Signature of Juneral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bruncho **Physician** DIRLUNON19 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the aftending physician To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending investigation 1 → Natural 2 → Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catansville Man Maide and 9714 Chio

State Registrar 31. Date filed (Month,

R 0 9 2008

32 Registrar's Signature

| 8-02710   |                | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  | 00 1150/                                  |
|---|----------------|--|---|
| homas Weather   |                | State of Maryland / Department of Health and Mental Hygiene  | 108   1530                                |
|   | R              | 1- For State Certificate of Death Reg. No.   | 3. Time of Death                          |
| Physicia  |                | 1. Decedent's Name (First, Middle Last)  2. Date of Dearn  Month  Day  Year  | 1320 hrs                                  |
| Medical Examir  | er             |  |   |
| -   | 4              | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   | ath                                       |
|   | н              | University Hospital Baltimore  |   |
| Funeral   | 5              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9.   | Country)                                  |
| Director  |                | 210-74-4783 1 LM 2 F 47 Yrs. Months Days Hours Min. 2.14.1961  | MI  |
|   | ᆘ              | Usual Residence of Decedent  |   |
| any   |                | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits                   |
| <b>≱</b>  | .              | Baltimore  | 1 Yes 2 No                                |
| ylane<br>ylane  | ᇍ              | 10g. Citizen of What C   | Country?                                  |
| E 28 M  | <u>ě</u>       | 5603 Way Pare Dad 27206 U.S.A  |   |
| 23a Chil  |                | 5903 Way Cross Pod 2006 U.S. 14. Race - Al Till Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-  | nerican Indian, Black,                    |
| t pe  | Jers.          | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Al White, et  |   |
| or it   | ᇍ              | 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 Lino specify: Specify:   | Nack                                      |
| ral",   |                |  | ess/Industry                              |
| hours<br>natu   | 밁              | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)   |   |
| n 72<br>an "  | 흥              | Elementary/Secondary (0-12) College (1-4 or 5+)  | abled                                     |
| or the  | Completed by   | Disabled Dis   | 40144                                     |
| Hyg<br>d oth  |                |  | NIA                                       |
| 21215-0036 ould be filed within 7 Mental Hygiene. marked other that ie event, the Medics  | 8              |  | State, Zip Code)                          |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | ₽ſ             |  |   |
| MD<br>nd 2 sho<br>alth and<br>m 27 is<br>aumati   |                | Date 20c Location - Cit  | y or Town, State                          |
| Fe, lan   | - 1            | 20a. Method of Disposition   |   |
| Baltimore,<br>permit. Pages I a<br>Department of He<br>Important: If ite  | l              | Marie on Engel 4 1412MM Rolling  | nore, MD                                  |
| Baltir permit. 1 Departm Importa  | ŀ              | 21. Signature of Funeral Service Licensee / 22. Name and Address of Facility Vacann C. Gracos For  | GENICES                                   |
| Light Total Bar   | -              | 1/1/2 All. 4905 York the Baltimore Mil 2/21  | ۵   |
| Physician   | $\neg$         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   | Approximate Interval<br>Between Onset and |
| Mudical   | Į.             | failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease   | Death                                     |
| aminer  | - 1            | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  |   |
|   | - 1            | b  |   |
|   | ē              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |
|   | Examiner       | Cause. Enter Underlying Cause C  |   |
| d /   | Ха             | events resulting in death) Last Due to (or as a consequence of):   |   |
| executed ian and ial - transit  | ical           | u.   |   |
|   |                |  |   |
| Box 68760, a death certificate be the attending physiciate for the attending physiciated for use as the buriated for use as the buriated  | ĕ              | F FEMALE: 23c. If yes, outcome of pregnancy  |   |
| 587<br>ertific  | an/            | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month   | Day Year                                  |
| ath c   | Sici           | 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  |   |
|   | Physician/Med  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions.  | ite to the cause of death?                |
| Records, P.O. B The law requires that the d cate has been signed by the page 2 should be detached   | by F           |  | Probably 4 V Unknown                      |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it and refer death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.   |                |  | ere autopsy findings available            |
| requ  | ompleted       | autopsy pri  | or to completion of cause of              |
| e law<br>e has  | Ē              | performed? de<br>1 ✓ Yes 2 No 1 √  | ath?  Yes 2 No                            |
| tal Rec   | O              | 26 Place of Death (Check only one)   |   |
| Vital F<br>ysician:<br>his certifi<br>director,   | Be             | examiner? Hospital: 1 Insertion 2 FR/Outnatient 3 DOA Other: Nursing Home 5 Residence 6  | Other:                                    |
| FVil<br>Physic<br>er this   | P              | 27 Manner of Dath 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred  | 1   |
| n of V<br>ding Phy.<br>After the  | on:            | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No   |   |
| ivision or Atteno after death Director;   | ati            | 2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number   | or Rural Route Number, City               |
| ivis<br>or A<br>after<br>Dire   | ti E           | 3 Suicide 6 Could not be 28e. Place of Injury - At nome, farm, street, factory, blice building, etc. or Town, State)   | ,   |
| [E] E [S]   | Certification: | 4 Homicide determined (Specify)  | a state d                                 |
| Hos<br>24 h<br>Fun<br>etely   |                |  | e to the cause(s)                         |
| To the Hospital within 24 hours To the Funeral completely filled  | edical         | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and so and manner stated.   |   |
| F % F 3   | Me             | ≥ 29b. Signature and title of certifier  | d (Month, Day, Year)                      |
|   |                | O.C.M.E. April 7, 2008   | 5   |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)   |   |
| 6   |                | Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |   |
| - C   | tate           | 22) Angiotrafia Cinnatura  |   |
| Regis   |                | THE TO DECOUDE REPORT A PART REPORT OF THE PART OF THE |   |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 200°% 2 2351 M Elizabeth Josephine Welch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NEN BURNE ANNE ARUNIX tOARHINGTON MEDILAL CENTER 6Actimo 2 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/07/1935 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 F Director 216-32-4136 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 119 Catalfa Avenue 21122 U.S.A. Funeral 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Early Childhood Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi ealth and Mental Hygiene. Coordinator Development is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Katlic Mary Novak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Catalfa Avenue, Pasadena, MD 21122 Gordon Welch / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 04/08/08 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NON-SMALL CELL LING CANCER **Physician** METACTATIE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi Exami and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: nse yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I Yes 2 No the 9□Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Certification: Division 1 Natural (Month, Day Year) 5 Pending investigation after death.

I Director: A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral I To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
Aml 2 · 2008 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

APR 09

ONABATO

Name and address of person by completed cause of death (Item 23a) (Type, Print) Holphal drife Glen Burne mid 21061. 32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4, 2008 9:35  $A^M$ April John Percy Wade /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 2/16/29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Year) 1**X**M 2□ F Months Maryland Director 79 216-24-9900 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21228 701 Maiden Choice Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, the ODEs. Motor Vehicles Judge 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite Ward John Percy Wade 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7575 Pelican Bay Blvd. Naples , Flordia 34108 Mrs. Mary Ann Martell / Sister 20b. Place of Disposition (Name of Badebaten Oremator) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/8/08 @ Loudon Park Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death NSOF Immediate Cause (Final 06 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending | IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Home 5 Residence 6 Other (Specify) 2 NO 10 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Leavilying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M Name and ddress of who completed cause of death (Item 23a) (Type, Print 9755 49 19 ide . Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 **Physician** Month Esther P. Warner 5 April 7 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Overlea Health And Rehab. N/A 9. Birthplace (State or Foreign Country) Baltimore der Tyear Til Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 255 Yrs 212-07-3459 Director 98 Mar. 17,1910 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits f show Items 23a or 28a-f showner must be notified at Maryland 1 Yes XXNo Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Overlea Health 6116 Belair Road USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Item Pages 1 and 2 should be filed within 72 hours after carn to Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examinet Black, White, etc. Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes XX No White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Sales Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Warner Corrie A. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Rohrback 2004 Carrs Mill Road, Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/8/2008 Parkville, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to ( a consequence Examiner e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditie contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed has been are 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 2 No Yes funeral director 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this eath 28a. Date of Injury 27. Manner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident (Month, Day Year) 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined etrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 4-7-2-008 29b. Signature and title of certifier

State Registrar

APR 09 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Brint)

2008

ven Blud, Baltimore mo 2/238

08-02721 . Edwin L. Zemo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| win L. Zemo  | 1              | Sta<br>- For State   | ate of Maryla             |                                  | rtment of tificate of |                           | and                  | Menta                  | al Hygi                   |                            | ı. No.      | 201                          | 18                           | 151            |
|--|----------------|--|---------------------------|----------------------------------|-----------------------|---------------------------|----------------------|------------------------|---------------------------|----------------------------|-------------|------------------------------|------------------------------|----------------|
| Physicia   |                | tegistrar<br>1. Oecedent's Name (First, Middl  | e,Last)                   |                                  |                       |                           |                      |                        |                           | Date of Oeath              |             | Year                         | 3. Time of Oe 1937 hrs       |                |
| edical Examin  |                |  | win                       |                                  | Zemo                  | b. City, Tov              | m orlo               | cation of              | A                         | pril 6, 200                | 8           | ounty of Death               |                              |                |
|  |                | 4a. Facility Name (if not institution 5 Sage Court   | n, give street and n      | umber)                           |                       | Pikesvil                  |                      | oution of              |                           |                            |             | imore Cou                    |                              |                |
| Funeral  |                | 5. Social Security Number  | 6. Sex                    | 7. Age (In yrs. la               | ast birthday)         | If Under                  | -                    | If Under               | _                         | . Date of Birth            | (MM/00/     | YYYY) 9. Bir<br>Foreig       | hplace (State                | ог             |
| Director   |                | 198-30-0229  | 1X M 2 F                  | 69                               | Yrs.                  | Months                    | Oays                 | Hours                  | Min.                      | Feb. 1                     | 8,19        |                              | untry) PA                    |                |
| ķ  | F              | Usual Residence of Oecedent  10a. State 10b. County  |                           | Inc. City.                       | Town or Location      | on                        |                      |                        |                           |                            |             |                              | 10d. Inside C                | ity Limits     |
| d<br>now an  |                |  | imore                     |                                  | Pikesvil              |                           |                      |                        |                           |                            |             |                              | 1 Yes                        | 2 <b>X</b> No  |
| ie Maryland<br>or 28a-f show any<br>fied at once.  |                | Maryland Balt<br>10e. Street and Number  | 111107 6                  |                                  | INCSVI                | 10f. Zip C                | ode                  |                        |                           | 10                         | g. Citizen  | of What Cou                  | ntry?                        |                |
| the Miss or 2  | ä              | 5 Sage Cour  | t                         |                                  |                       | 2                         | 2120                 | 8 _                    |                           |                            |             | U.S.A.                       |                              |                |
| t be no  | Funeral        | 11. Marital Status   |                           | ecedent Ever in U.<br>Forces?    | .S. 13. Was           | S Oecedent<br>es, specify | of Hispa<br>Cuban, I | anic Origi<br>Mexican, | n? ( Specit<br>Puerto Ric | fy Yes or No-<br>an, etc.) | 14          | . Race - Amer<br>White, etc. | ican Indian, Bl              | ack,           |
| er dear  |                |  | orced If Yes, Give Yo     | 2 No                             | 1                     | Yes 2                     | ( No                 | specify:               |                           |                            | Sp          | ecify: W                     | hite                         |                |
| ours afi<br>atural   | d b            | 15. Oecedent's Education (Spe  | or Dates:                 |                                  | 16a. Oeceden          | t's Usual Oo              | cupatio              | n (Give k              | ind of work               | done                       | 16b. Kind   | d of Business/               | Industry                     |                |
| 6<br>n 72 hc<br>an "n:<br>ical E3  | lete           | Elementary/Secondary (0-12)  | , and a                   | (1-4 or 5+)                      |                       |                           |                      |                        | , , , , , , ,             |                            | Vot         | orinar                       | y Medio                      | ine            |
| -003<br>I withii<br>giene.<br>ther the   | Completed      | 17. Father's Name (First, Middle   |                           | 5+                               | ve                    | terina                    | 18                   | II<br>3. Mother's      | Name (Fi                  | rst, Middle, M             |             |                              | y Medic                      | ,1110          |
| 21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be             | Pete   |                           | mo                               |                       |                           |                      |                        |                           | luby                       | ٧.          |                              | ehman_                       |                |
| nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygene. It filten 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at once. | ٩              | 19a. Informant's Name/Relations  |                           | <b>.</b>                         |                       |                           |                      |                        |                           |                            |             | or Town, Stat                | land 2                       | 214            |
| , MD<br>and 2 sho<br>ealth and<br>lem 27 is<br>traumati  |                | Edwin L. Zemo,   | ur. 30                    |                                  | Place of Dispos       | ition (Name               |                      |                        |                           | ate                        |             | cation - City o              |                              |                |
| altimore,<br>rmit. Pages I ar<br>spartment of Her<br>iportant: If ite  |                | 1 Burial 2 X Crematio  |                           | IIOIII State                     | crematory or oth      |                           | 2 CO                 | rn                     | 4-9-                      | 2008                       | l To        | wson                         | Maryla                       | and            |
| Baltimo<br>permit. Page<br>Department o<br>Important:<br>injury or oth   | 1              | Donation 5 Other S   | pecify:<br>Licensee       |                                  | 22. N                 | lame and A                | ddress o             | of Facility            | Ruck                      | Tows                       | n Fu        | neral                        | Home,                        |                |
| ii ii De <b>ii</b>   | 0.3            | 23a. Part I. Enter the disease, o  | 19an                      |                                  | 1                     | 1050                      | York                 | Коа                    | a 7                       | owson,                     | , Mar       | yland                        | 21204                        | ite Interval   |
| Physician<br>Medical   |                | 23a. Part I. Enter the disease, o failure. List only one cause                               | e on leach line.          |                                  |                       |                           | dying, s             | ucii as ce             | ardiac or re              | Spiratory arre             | 331, 011001 | ., 0, 1,00.1                 | Between                      | Onset and eath |
| aminer   |                | Immediate Cause (Final disease or condition resulting in death)                              |                           | erotic Cardiov                   |                       | ease                      |                      |                        |                           |                            |             |                              | 1                            |                |
|  | L              | Sequentially list conditions,  | b                         |                                  | -0.                   |                           | _                    |                        | _                         |                            |             |                              | -                            |                |
|  | nine           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated |                           | a consequence                    | or):                  |                           |                      |                        |                           |                            |             |                              | 290                          |                |
| cuted and transit  | Examiner       | events resulting in death) Last  | Due to (or as             | a consequence                    | of):                  |                           |                      |                        |                           |                            |             |                              | 1                            |                |
| ē , ,  | edical         | UNPENDED   | a                         |                                  |                       |                           | •                    |                        |                           |                            |             |                              |                              |                |
|  | Med            | IF FEMALE:   |                           | s, outcome of pre                | gnancy                |                           | TI                   |                        |                           | 107-23                     | 1 200.      | Oate of delive               | . ,                          | Vens           |
| Box 68760<br>death certificate b<br>the attending physical for use as the bu   | Physician/M    | 23b. Was decedent pregnant in past 12 months?  | 1                         | e birth<br>gnant at time of d    |                       | etal death<br>ther (Speci | 3 <u>[</u><br>fv)    | Ectopic                | pregnand                  | У                          | ^           | Month                        | Day                          | Year           |
| Box<br>death<br>the atte   | nysic          | 1 Yes 2 No 9 U   |                           | known                            |                       |                           |                      |                        |                           |                            |             |                              | - 45                         | dooth?         |
| P.O.   | by Pl          | Part II. Other significant cond  |                           | to death but not                 | resulting in the      | underlying                | cause gi             | iven in Pa             | art I.                    |                            |             |                              | o the cause of obably 4      |                |
| ls, P.C<br>quires that<br>en signed<br>ald be deta   | ted t          | Chronic alcohol abu  | se                        |                                  |                       |                           |                      |                        |                           | 24a. Was                   | an          | 24b. Were                    | autopsy finding              | gs available   |
| Records, The law require   | Completed      |  |                           | <del></del>                      |                       |                           |                      |                        |                           |                            | rmed?       | death?                       |                              | No             |
| tal Rection: The certificate ector, page   |                | 25. Was case referred to medic   | al T                      |                                  |                       | 2                         | 6.Place              | of Death               | (Check on                 | 1 Yes                      | 2 No        | 1 🗸                          | res z                        | 140            |
| of Vital<br>ng Physician:<br>After this certi<br>nneral directoi   | o Be           | examiner?  | Hospital: 1               | Inpatient 2                      | ER/Outpatien          | t 3 D                     | DA                   | Other4                 | Nursing                   | Home 5                     | Residen     | ce 6 🗸 Oth                   | er: Scene                    |                |
| n of Ving Ph   | n: To          | 27. Manner of Death  | 28a. Da<br>(Mo            | ate of Injury<br>onth, Day,Year) | 28b. Time of          | Injury 2                  | -                    | y at Work<br>'es 2     |                           | 8d. Describe               | how injur   | y occurred                   |                              |                |
| Sion<br>Attendi<br>death.<br>ctor:   | atio           |  | estigation                | lace of Injury - At              | hama farm stre        | et factory                |                      |                        |                           | 8f. Location (             | Street an   | d Number or                  | Rural Route N                | umber, City    |
| Division pital or Attendir ours after death. Ieral Director: A   | Certification: | del  | uld not be ermined (Speci |                                  | nome, ram, sue        | et, lactory,              | OHICC D              | unung, o               |                           | or Town,                   |             |                              |                              |                |
| spi<br>spi   |                | 29a. Certifier   | Physician: To the         | best of my knowle                | edge, death occu      | irred at the              | time, da             | ite and pl             | ace, and d                | ue to the cau              | se(s) and   | manner as st                 | ated.                        |                |
| To the Hos<br>within 24 h<br>To the Fur  | Medical        | one) 2 Medical Ex  | aminer: On the bas        | sis of examination<br>or stated. | and/or investiga      |                           | _                    |                        |                           | the time, date             |             |                              | tne cause(s)  Month, Day, Ye | ar)            |
|  | Ž              | 29b, Signature and title of certi  | her                       | A                                |                       | 290                       | O.C.I                | e number<br>M.E.       |                           |                            |             | 7, 2008                      | ,onus, bay, re               | /              |
|  |                | 30. Name and address of person   | 2 1                       | aus of death (the                | -m-23a)               |                           |                      |                        |                           |                            |             |                              |                              |                |
| 10+1   |                | Zabiullah Ali, M.D.  | Assistant Med             | /                                |                       | nn Stree                  | t, Balti             | imore,                 | MD 212                    | 01                         |             |                              |                              |                |
|  | tate           | 31. Oate filed (Morning Ry, Yoa  | 9 2008 <sup>32</sup>      | aistrar's Signa                  | eturk &               | 3460                      |                      |                        |                           |                            |             |                              |                              |                |
| Regis  | trar           |  | -                         |                                  |                       |                           |                      |                        |                           |                            |             |                              |                              |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rodney Month Adams **Physician** Lloyd 2008 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico If Under 24 Hrs. Hours Min. Birthplace (State or Foreign
Country) 8. Date of Birth **Funeral** Days Months 1 M 2 □ F 2/20/1944 Florida 213-48-2251 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 617 Homer St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) car dealership parts manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rodney L. Adams Martha Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 Headley Ct., Fruitland, MD 21826 Anna Ball/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/28/08 Parsons Cemetery Salisbury, MD Euneral Service Licent 22. Name end Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and as the bunial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an autopsy performed? 1□ Yes 2□ No has this certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Ampatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical /2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) MAR 2 6 2008

5 Huestin



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARLS

00058410

CT. SAlis greeny up 21802

State Registrar

DHMH 17 Rev 1/2001

P

0x 265

Grantsville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

SABAhAt

APR 0 9

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                |  |                  | For<br>1_State  | State of  | Marylan                          |                                  | artmen                           |                          |                        | and M      | lental Hyç                       |                 | 2000                | Harden and the same of the sam | 543               |
|----------------|--|------------------|---|---|----------------------------------|----------------------------------|----------------------------------|--------------------------|------------------------|------------|----------------------------------|-----------------|---------------------|--|-------------------|
|                |  |                  | Registrar  1. Decedent's Name (First, Middle,   | Last)   |                                  |                                  | inicati                          | COIL                     | Jeann                  |            | 2. Date of Dea                   | Reg. No.        | 2000                | 3. Time of   | Death             |
|                | Physici  |                  |   | n W. Brown                                      |                                  |                                  |                                  |                          |                        |            | Month<br>March                   | Day<br>21       |                     | 2148   | M                 |
| 16.50<br>16.50 | /Medic<br>Examir   |                  | 4a. Facility Name (If not institution,  | <u> </u>  | er)                              |                                  | 4b. City,                        | Town, or                 | Location of            | of Death   | nar cn                           |                 | County of Dea       |  |                   |
|                | Examili  | ler              | Anne Arundel Medic  |   | /                                |                                  | A                                | nnapo                    | lis                    |            |                                  |                 | Anne A              | rundel   |                   |
|                | Funeral  |                  |   |   | Age (In yrs.                     | last birthday)                   | If Under                         | 1 Year                   | If Under               |            | 8. Date of Birt                  | h<br>( Vaar)    | 9. Bi               | thplace (State of  | or Foreign        |
| ь              | Director   |                  | 577-46-4419   | 1□M 2⊠F   | 74                               | Yrs.                             | Months                           | Days                     | Hours                  | Min.       | (Month, Da)<br>May 03,           |                 |                     | o <i>untry)</i><br>Virginia  |                   |
|                | Pu ,   |                  | Usual Residence of Decedent   | •   | 140- 0:4                         | . T 1 -                          |                                  |                          |                        |            |                                  |                 |                     | Table Indian   | 2.11              |
|                | anylar<br>show<br>d at   | <u> </u>         | 10a. State 10b. County  |   | Toc. Cit                         | y, Town or Lo                    | cation                           |                          |                        |            |                                  |                 |                     | 10d. Inside Ci   | ty Limits<br>2⊠No |
|                | he M<br>8a-f<br>otifie   | ecto             | Maryland Montgo   | omery   |                                  |                                  |                                  |                          | ver Sp                 | ring       |                                  | 10 0'''         |                     | 1  | 22110             |
|                | with t   | ä                | 10e. Street and Number  |   |                                  |                                  | 10f. Zip                         | Code                     | 2007.0                 |            |                                  | rog. Citi       | zen of What C       | •  |                   |
|                | s 23s  | era              | 1220 East West H  | 12. Was Decede                                  | nt Ever in II                    | c 112                            | Man Dagge                        | tont of Ui               | 20910                  |            | oify Vos or No                   |                 | U.<br>14. Race - Am | S.A.   |                   |
|                | 72 hours after death with the Maryland<br>hatural", or items 23a or 28a-f show<br>disal Examiner must be notifled at   | Funeral Director | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>                          | Armed Force                                     | es?                              | .5.                              | If Yes, spec                     | cify Cuba                | n, Mexicar             | i, Puerto  | ecify Yes or No-<br>Rican, etc.) |                 | Black, Wh           |  |                   |
| 36             | Irs af   | by               | 3 ☑ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Date                    |                                  |                                  | 1 ☐ Yes                          | 2⊠ No                    | Specify:               |            |                                  |                 | Specify:            | Black  |                   |
| 21215-0036     | 2 hou  | P                | 15. Decedent's  | Education                                       |                                  | 16a. Dece                        | dent's Usua                      | al Occupa                | ation                  |            | - 1                              | 16b. Ki         | nd of Business      | s/Industry   |                   |
| 215            | within 7;<br>iene.<br>than "n<br>the Medi  | Completed        | (Specify only highest<br>Elementary/Secondary (0-12)  | grade completed) College (1-4                   | or 5+)                           | (Give                            | kind of woi<br>DO NOT us         | rk done d<br>se retired, | luring mos:<br>)       | t of worki | ng                               |                 |                     |  |                   |
| 21             | d wit<br>gien<br>gien<br>er tha  | ĕ                | 12  |   |                                  | Еп                               | ployme                           | nt Se                    | rvices                 | \$         |                                  |                 | D.C. G              | overnment  |                   |
|                | al Hy<br>l othe  | Be (             | 17. Father's Name (First, Middle, La  | ast)  |                                  |                                  |                                  |                          | 18. Mothe              | er's Name  | (First, Middle,                  | Maiden          | Surname)            |  |                   |
| <u>la</u>      | Ment Ment  | 흔                | Leander   | Waddell   |                                  |                                  |                                  |                          |                        | Bes        | sie Mills                        | 3               |                     |  |                   |
| Maryland       | d 2 should be filed within 7 th and Mental Hygiene.<br>7 is marked other than "r<br>traumatic event, the Med   |                  | 19a. Informant's Name/Relationship  | (Type. Print)                                   |                                  | 19b. Mailii                      | ng Address                       | (Street a                | and Numbe              | er or Rura | al Route Numbe                   | er, City o      | r Town, State,      | Zip Code)  |                   |
| ≥              | and<br>ealth<br>n 27   |                  | Donna Ball - Da   | aughter   |                                  |                                  |                                  |                          | ne, Up                 |            | larlboro,                        |                 |                     |  |                   |
| ore            | iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3   | B □Removal from Sta                             |                                  | Place of Dispo<br>cemetery, crei | sition (Nan<br>matory or o       | ne of<br>ther plac       | e)                     |            | Date                             | 20c. Lo         | cation - City o     | r Town, State  |                   |
| ä              | Pag<br>ment<br>ant:<br>lury o  |                  | 4 □ Donation 5 □ Other (Spe   |   |                                  | t Linco                          | ln Crem                          | natory                   | 7                      | 03/27      | /2008                            | Brer            | ntwood, 1           | Maryland   |                   |
| Baltimore,     | permit. Pages 1 and 2 s<br>Department of Health ar<br>Important: If Item 27 is<br>any Injury or other trau   |                  | 21. Signature of Funeral Service Li   | cersee  | 1.                               | 22<br>H                          | 2. Name an<br>ines-R             | d Addres<br>inald        | s of Facilit<br>i Fune | y<br>ral H | ome, Inc.                        |                 |                     |  |                   |
|                | <u>~</u> □ = @ Ø   |                  | Comet   | New   | 20m                              |                                  |                                  |                          |                        |            |                                  |                 | pring, M            | aryland 2  |                   |
|                |  |                  | 23 Part1. Enter the disease, or c<br>shock, or heart failure. List of                                       | omplications that cau<br>nly one cause on eac   | sed the deat<br>h line.          | h. Do not ent                    | er the mod                       | e of dying               | g, such as             | cardiac o  | or respiratory ar                | rest,           |                     | Approximat<br>Interval Bet<br>Onset and  | ween              |
|                | Physician  | ľ                | Immediate cause (Final disease or condition resulting in death)   | _a. He-   | norr                             | hagi                             | 2 0                              | ect                      | 650                    | et         | the                              | 1,              | vev                 | Onder and  | Death             |
|                | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or                                      | as a conseq                      | uence of                         | - ,                              |                          |                        |            |                                  |                 |                     |  |                   |
| п              |  | _                | Sequentially list conditions,   | b   | as a conseq                      | uence of):                       |                                  |                          |                        |            |                                  |                 |                     | -  |                   |
|                | ted<br>nsit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Bue to (or                                      | us a conseq                      | acrice ory.                      |                                  |                          |                        |            |                                  |                 |                     |  |                   |
| _6             | xecu<br>al-trai  | xar              | that initiated events<br>resulting in death) Last   | c<br>Due to (or                                 | as a conseq                      | uence of):                       |                                  |                          |                        |            |                                  |                 |                     |  |                   |
| 8760,          | cate be executed oblysician and the burial-transit   | dical E          |   |   |                                  |                                  |                                  |                          |                        |            |                                  |                 |                     |  |                   |
| 289            | ficate<br>physics the  | edic             |   | - d   |                                  |                                  |                                  |                          |                        |            |                                  |                 |                     |  |                   |
| Вох            | nding pluse as t   | N/U              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outco                              |                                  |                                  | -                                |                          |                        |            |                                  |                 | 23d. Date of de     | elivery  |                   |
| m              | death<br>e atten<br>ed for u   | cial             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnar                                       | h 2□Feta<br>ntattime ofd         |                                  | ⊒Ectopic pr<br>⊒Other <i>(sp</i> |                          |                        |            |                                  |                 | Month               | ,  | Year              |
| 0              | t the o  | Physician/Mec    | 9 □ Unknown   | 9□Unknow  | n                                |                                  |                                  |                          |                        |            |                                  |                 |                     |  |                   |
| о,<br>С        | w requires that the death certifit<br>been signed by the attending p<br>should be detached for use as  | by P             | Part II. Other significant condition  | s contributing to deat                          | h but not res                    | ulting in the u                  | nderlying ca                     | ause give                | en in Part I.          |            | 23e. Did to                      | obacco u        | ise contribute      | to the cause of o  | death?            |
| Vital Records, | equire<br>en sig   | pa               |   |   |                                  |                                  |                                  |                          |                        |            | 1 🗆 1                            | es 2            | No 3∏F              | Probably 4   | Unknown           |
| 000            | aw re<br>Is be   | Completed        |   |   |                                  |                                  |                                  |                          |                        |            | 24a. Was                         |                 | 24b. Were a         | utopsy findings  | available         |
| m.             | The law<br>te has b  | шо               |   |   |                                  |                                  |                                  |                          |                        |            |                                  | rmed?<br>2 □ No | death?              |  | ause of           |
| ita            | Iclan: Th<br>certificate<br>ector, pag   | Be C             | 25. Was case referred to medical  |   |                                  |                                  |                                  |                          | 26. Place              | of Death   | (Check only o                    |                 | 7.010               | 3 2 110  |                   |
| r <            | nysici<br>lis ce<br>direc  | ToB              | examiner?<br>1 ☐ Yes 2☐ No  | Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | atient 2                         | ER/Outpatier                     | nt 3 DO                          | Othe                     | er: 4□Nu               | rsing Ho   | me 5 Resid                       | lence           | 6 □Other (Sp        | ecify)   |                   |
| 0              | Attending Physician: r death. sctor: After this certific by the funeral director,  | ü                | 27. Manuer of Death  ☐ Natural 5 ☐ Pending  | 28a. Date of                                    | Injury<br>Day Year)              | 28b. Time o<br>Injury            | f 2                              | 28c. Injury<br>Work      | at                     |            | 28d. Describe h                  | now injur       | y occurred          |  |                   |
| Ö              | endir<br>ath.<br>or: Al  | atic             | 2 ☐ Accident investiga  | tion  |                                  | , ,                              | M                                |                          | Yes 2□                 | No         |                                  |                 |                     |  |                   |
| Division or    | if or Attendater death.  Director: A d in by the f   | Certification:   | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | 28e. Place of                                   | injury - At ho<br>, etc. (Specif | ome, farm, str                   | eet, factory                     | , office                 |                        |            | 28f. Location (S<br>City or Tox  |                 |                     | Rural Route Nun  | nber,             |
|                | ital carries af  |                  |   |   |                                  |                                  |                                  |                          |                        |            |                                  |                 |                     |  |                   |
|                | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | edical           |   | Physician: To the be<br>xaminer: On the bas     | is of examina                    |                                  |                                  |                          |                        |            |                                  |                 |                     |  | s)                |
|                | the or th | Med              | 29b. Signature and title of certifier   | and manne                                       | r stated.                        |                                  | 290                              | . License                | e number               |            |                                  | 29d. Dat        | te signed (Mor      | ntt, Day, Year)  |                   |
|                | F≥Fŏ   |                  | 1/6   |   | MO                               |                                  | 1                                | 00                       | -1                     | 8-         | 7                                | 2               | 12 2                | / c=   |                   |
|                | 10   |                  | 30. Name and address of person w  | ho completed cause                              | of death (Itan                   | 23a) /Tupo                       | Print)                           | アン                       | <u> </u>               | 0          |                                  | 7               | 1451                | 8  |                   |
|                |  |                  | oo. Name and address of person w  | The lead cause                                  | or deam (Itell                   | . zoa, (Type,                    | Y                                | _                        | H                      | 1          | MI                               | 1               | / (                 | 1.   | > ×               |
|                | Sta  | te               | 31. Date filed (Month, Day, Year)   | 32. <b>3</b> 9                                  | istrar's Signa                   | iture                            | Lun                              | _                        | 1740                   | na         | 1 1/4                            | - C//C          | - 64                | - n J  |                   |
|                | Registr  |                  | MAR 2 6   | 2008  | Care I                           | K. A                             | MALL                             |                          |                        |            |                                  |                 |                     |  |                   |

|                     |   |                | For<br>1_ State  | State of M                               | arylan              |                             | artment of H   |                           | -                             | _             | 0000                      | 1151.1.  |
|---------------------|---|----------------|--|--|---------------------|-----------------------------|--|---------------------------|-------------------------------|---------------|---------------------------|--|
|                     |   |                | Registrar  |  |                     | Cei                         | rtificate of L   | Death                     |                               | Reg. No       | ZUUÖ                      | 11344  |
|                     | Physicia  | an             | 1. Decedent's Name (First, Middle, Last)  Helen Becra  | .f+                                      | ъ                   | ean                         |  |                           | 2. Date of De<br>Month        | Da            |                           | 3. Time of Death                                   |
| 1                   | /Medic  |                | 4a. Facility Name (If not institution, give si   |  |                     | ean                         | 4b. City, Town, or   | Location of Dea           | March                         | 24            | 2008<br>County of Death   | 9:32 A <sup>M</sup>                                |
|                     | Examin  | er             |  |  |                     |                             |  |                           | ui i                          | 1             |                           |  |
|                     | Funeral   |                | 401 Russell Avenue 5. Social Security Number 6. Sex  |  | je (In yrs. i       | ast birthday)               | If Under 1 Year  |                           |                               | th            | Montgom                   | place (State or Foreign                            |
| П                   | Director  |                | 215-10-9996  | M 212 F                                  | 103                 | Yrs.                        | Months Days  | Hours Min                 | Oct. 1                        |               |                           | vland  |
|                     | pu ,  |                | Usual Residence of Decedent  10a. State 10b. County  |  | I 100 Cib           | /. Town or Lo               | cotion   |                           |                               |               |                           | 10d. Inside City Limits                            |
|                     | laryla<br>shov  | ō              |  |  |                     |                             |  |                           |                               |               |                           | 1 ⊠Yes 2 □ No                                      |
|                     | the M<br>28a-f<br>notifie   | Director       | Maryland   Montgomer   | У  | Ga                  | ither                       | 10f. Zip Code  |                           |                               | 10a Cir       | tizen of What Cou         |  |
|                     | with<br>ta or   |                |  | # 605                                    |                     |                             | ·  | 7                         |                               | 109. 01       |                           |  |
|                     | ns 23   | Funeral        | 401 Russell Avenue   | 2. Was Decedent                          |                     | S. 13.                      | 2087 Was Decedent of Hi f Yes, specify Cuba                      | ·                         | Specify Yes or No             | )-            | United<br>14. Race - Amer | ican Indian,                                       |
| و                   | be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at |                | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes 2 【                |                     | 1                           |  |                           | rto Rican, etc.)              |               | Black, White              | e, etc.  |
| ğ                   | ral", c   | d by           | 3 ☑ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:           |                     |                             | 1∐ Yes 2∭∑ No  | Specify:                  |                               |               | Specify: W                | hite   |
| 2-0                 | 72 h  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)                      |                     | 16a. Dece<br>(Give          | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | ation<br>Juring most of w | orking                        | 16b. K        | (ind of Business/I        | ndustry  |
| 121                 | vithin<br>ane.<br>Ihan '  | ш              | Elementary/Secondary (0-12)  | College (1-4or                           | 5+)                 |                             |  |                           |                               | <sub>T-</sub> |                           | Company  |
| 2                   | Hygie<br>Hygie<br>ther t  |                | 12   17. Father's Name (First, Middle, Last)   |  |                     | L                           | Secretary  |                           | ame (First, Middle            |               | nsurance                  | Company  |
| au                  | ed ala  | o Be           | Charles  | E. ]                                     | Becra               | f+                          |  |                           | Katie                         |               | Penn                      |  |
| Maryland 21215-0036 | 2 should be and Mental Is marked (aumatic ev  | 욘              | 19a. Informant's Name/Relationship (Typ  |  | веста               | T                           | ng Address (Street a   | and Number or F           |                               |               |                           | ip Code)   |
|                     | s 1 and 2 should<br>if Health and Men<br>item 27 Is marke<br>other traumatic  |                | Helen Isabel Irvine  | e/Niece                                  |                     | 405 S                       | outh Fred  | lerick A                  | venue, G                      | aith          | nersburg                  | , MD. 20877  |
| e,                  |   |                | 20a. Method of Disposition   |  | 20b. P              |                             | sition (Name of<br>natory or other plac                          |                           | Date                          |               | ocation - City or         | ·  |
| Ĕ                   | Pages<br>nent of<br>ant: If its<br>ary or o   |                | 1 <del>☑</del> Burial 2 □ Cremation 3 □ Re<br>4 □ Donation 5 □ Other ( <i>Specify</i> )                | emoval from State                        |                     |                             | k Cemeter  | 1                         | 7/2008                        | Gat           | ithersbu                  | rg, MD.  |
| Baltimore,          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  | •-             | The state of Funeral Service License   | 010                                      | 0                   | 1 22                        | 2. Name and Addres   | s of Facility D           | eVol Fun                      | eral          | l Home                    |  |
| n                   | 90 = 20   |                | Mechan   | XII                                      | للبار               | V-10                        | East Dee   | r Park                    | Dr., Gai                      | ther          | rsburg, 1                 | MD. 20877  |
|                     |   |                | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only one                    | ations that cause<br>e cause on each li  | d the death<br>ine. | n. Do not ent               | er the mode of dyin  | g, such as cardia         | ac or respiratory a           | rrest,        |                           | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician   |                | Immediate Cause (Final disease or condition resulting in death)  | Dementia                                 | a                   |                             |  |                           |                               |               |                           | Oriset and Death                                   |
|                     | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as                            | a consequ           | uence of):                  |  |                           |                               |               |                           |  |
|                     |   | <u>-</u>       | Sequentially list conditions, if any leading to immediate  | Due to (or as                            | a consedi           | ience of):                  |  |                           |                               |               |                           |  |
|                     | nsit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Undeade or night) that initiated events c. | 240 10 (01 40                            | a concequ           | 201100 017.                 |  |                           |                               |               |                           |  |
| ,                   | execu<br>n and<br>al-tra  | Exai           | that initiated events resulting in death) Last   | Due to (or as                            | a consequ           | uence of):                  |  |                           |                               |               |                           |  |
| 8/60                | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit                    | dical          | d  |  |                     |                             |  |                           |                               |               |                           |  |
| Ö                   | tificat<br>ig phy<br>as th  | ledi           |  |  |                     |                             |  |                           |                               |               |                           |  |
| ROX                 | eath certific<br>attending p<br>for use as  | Physician/Me   | 230. Was decedent pregnant   | lc. If yes, outcome<br>1 □Live birth     |                     |                             | Ectopic pregnancy  |                           |                               |               | 23d. Date of deli         |  |
|                     | ed fo   | sici           | in the past 12 months?<br>1 □ Yes 2 🛣 No   | 4□Pregnant a                             |                     |                             | Other (specify)  |                           |                               |               | Month                     | Day Year   |
| J.                  | at the de   | Phy            | 9 Unknown  |  |                     | data e in ab e              |  | - i- D-41                 | oon Did                       |               |                           | th of do-sh-0                                      |
|                     | w requires that<br>been signed b<br>should be deta  | by             | Part II. Other significant conditions conf<br>Ischial Decubitis  | inbuting to death b                      | out not rest        | ining in the u              | nderlying cause give   | en in Part I.             |                               |               |                           | the cause of death?  bbably 4 □Unknown             |
| Hecords,            | requ  | Completed      |  |  |                     |                             |  |                           | -                             |               |                           |  |
| န္                  | 0 <u>E</u> 0  | nple           | `  |  |                     |                             |  |                           | 24a. Was                      |               | prior to c                | topsy findings available completion of cause of    |
| _                   | ate Th  |                |  |  |                     |                             |  |                           | 1□ Yes                        | 2 <b>X</b> N  | death?<br>o 1 ☐ Yes       | 2□No   |
| VIta                | ysiclan:<br>is certific<br>director,  | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No   | ospital:                                 |                     | ED/Outrotion                | t 3 DOA Othe   |                           | eath (Check only o            |               |                           |  |
| Ö                   | a Phy<br>er this<br>eral d  | $\vdash$       | 27. Manner of Death  | 28a. Date of Inju                        | ury                 | ER/Outpatier<br>28b. Time o |  | - TI INUISHING            | Home 5 🗷 Resi                 |               |                           | cify)  |
| DIVISION            | nding F<br>ith.<br>r: After<br>e funera   | tior           | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Da                               | ay Year)            | Injury                      |  | <br Yes 2 ☐ No            |                               |               |                           |  |
| <u>S</u>            | Atte  | ifica          | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of inj                        | jury - At ho        | me, farm, str               | eet, factory, office   |                           | 28f. Location (<br>City or To |               |                           | ral Route Number,                                  |
| 5                   | tal or<br>s afte<br>al Dir<br>ed in   | Certification: | 4 Ditomode   | building, e                              | ic. (Specif)        | ' <i>'</i>                  |  |                           | City of 10                    | wii, Stat     | e)                        |  |
|                     | Hospi<br>t hour<br>uner   |                | 29a. Certifier 1  ☐ Certifying Physic (Check only 2  ☐ Medical Examin                                  | ician: To the best<br>er: On the basis o | of my kno           | wledge, death               | occurred at the tin  | ne, date and place        | ce, and due to the            | cause(s       | s) and manner as          | stated.  |
|                     | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to     | Medical        | 29b. Signature and title of certifier  | and manner st                            |                     |                             | 29c. License   |                           |                               |               |                           |  |
|                     |   | -              | 255. Signature and title of certifier  | 1  |                     | NOV                         | 250. LIGHTSE   | i C > C ·                 | ,                             |               | ate signed (Month         |  |
|                     | 10  |                | 30. Name and address of person who cor   | rench                                    | loath /li-          | 220\ /T:==                  | Print)   | 1724                      | 7                             | 1110          | 10h 24, .                 | 2008   |
|                     |   |                | John R. Melnick, M.  |  |                     |                             |  | thershu                   | ro. Marv                      | land          | 20879                     |  |
| 3                   | Sta   | te             | 31. Date filed (Month, Day, Year)  | 32 Registr                               | rar's Signa         | ture                        | a .  | CITCE SDU.                | b, mary.                      | _4114         | . 2007)                   | -  |
|                     | Registr   | ar             | MAR 2 6 200  | S STORE                                  | يكر م               | ture                        | W.   |                           |                               |               |                           |  |

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

sician and burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed I Director: / within 24 hours after dea To the Funerel Directo completely filled in by th

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rel', or Itams 23a or 28a-f show L'Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "Teturel", or Items 23.
ury or other treumatic event, "the Medical Exprised must must

permit. Pages 1 Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

Director

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2

with the Maryland

| Sequentially list conditions,   | Due to (or as a consect   | quence of):   |                                  |  |                                 | unknown   |
|---|---|---|----------------------------------|--|---------------------------------|---|
| day, keading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consect  | beovascular Aco   | rident                           |  |                                 | Unknown   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                   | 23c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of o<br>9 ☐ Unknown | al death 3 Ectopic pregnancy  |                                  |  | 23d. Date of de<br>Month        | Blivery<br>Day Year                               |
| Part II. Other significant conditions of  | ontributing to death but not re   | sulting in the underlying cause given in Pa   | art I.                           | 23e. Did tobacco                           |                                 | to the cause of death?  Probably 4 Minknown       |
|   |   |   |                                  | 24a. Was an autopsy performed?             | death?                          | autopsy findings available completion of cause of |
| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No   | Hospital: 1 ☐ Inpatient 2 ☐   | ( a. 1) - 1-1   | Ace of Death C                   | Check onl one                              | 6 □Other (Sp                    | ecify)  |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of lnjury at Work?  M 1 ☐ Yes 2   | 280                              | Describe how inju                          |                                 |   |
| 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci  | nome, farm, street, factory, office (fy)  | 28f                              | Location (Street a.<br>City or Town, Stat  |                                 | Rural Route Number,                               |
| 29a. Certifier 1 Certifying Ph. (Check only one)  | ysician: To the best of my kn<br>niner: On the basis of examin-<br>and manner stated.               | owledge, death occurred at the time, date ation and/or investigation, in my opinion, or | and place, and<br>death occurred | due to the cause(s<br>at the time, date an | s) and manner and place, and du | as stated.<br>le to the cause(s)                  |
|   |   | 29c. License numb   | er                               | 29d. Da                                    | ate signed (Mor                 | nth, Day, Year)                                   |
| 29b. Signature and title of certifier   | iders m)  | D00233  |                                  | 1  |                                 |   |

DHMH 17 Rev 1/2001

State Registrar

THVA

31. Date filed (Month, Day, Year) MAR 2 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                      |  |                              | 1 - State of Maryland / Dep  | ertificate of Death  | Reg. N   |   |
|----------------------|--|------------------------------|--|--|--|---|
| П                    | Physici  | an                           | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month  | 3. Time of Death  |
|                      | /Medic   |                              | Alice Jean Bass  |  | March 16.  | 2008 11:45 A M  |
|                      | Examin   |                              | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | 4  | 4c. County of Death   |
|                      |  |                              | Fort Washington Nursing Home   | Fort Washington  | n  | Prince George's   |
|                      | Funeral  |                              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday   | If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Yea   | Birthplace (State or Foreign  |
|                      | Director   |                              | 578-68-7893 1□ M 27 F 59 Yrs.  |  |  | 1948 Washington, DC   |
|                      | pug *  |                              | Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or L   | ocation  |  | 10d. Inside City Limits   |
|                      | aryla<br>sho   | 5                            | Tod. Gity, Town of E   | Cocation   |  | XXYes 2 No  |
|                      | Ba-f   | Scto                         |  | shington   |  |   |
|                      | vith ti  | Director                     | 10e. Street and Number   | 10f. Zip Code  | 10g. 0   | Citizen of What Country?  |
|                      | filed within 72 hours after death with the Maryland<br>Hygiene.<br>kther than "natural", or Itams 23a or 28a-f show<br>ont, I're Medical Evariliner must be notified at  |                              | 12906 Kilburnie Circle   | 20744  |  | ited States   |
|                      | er de<br>Ham   | by Funerai                   | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  | . Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)   | 14. Race - American Indian,<br>Black, White, etc.   |
| 36                   | s aft  | yΕ                           | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   | 1 ☐ Yes 🏋 No Specify:  |  | African Specify:  |
| 21215-0036           | hour   | pe p                         | A.   |  | 1  | American  |
| 5                    | n 72<br>"na  | Completed                    | (Specify only highest grade completed) (Give   | edent's Usual Occupation<br>e kind of work done during most of work<br>DO NOT use retired)   | ing 16b.   | Kind of Business/Industry   |
| 7                    | withi<br>Bne.<br><b>than</b>   | mc<br>du                     | Elementary/Secondary (0-12) College (1-4or 5+)   | ·  |  | During a few  |
|                      | filed<br>Hygi<br>ther<br>int, I  | ပိ                           | 2 years Co   | ounselor   | e (First, Middle, Maide  | Private   |
| an                   | d be<br>ontal  | Be o                         |  |  | 11. 11. 12. 12. 12. 12. 12. 12.  | on carrierney   |
| Maryland             | d Me<br>mark<br>mati   | ပ္                           | Roselvelt Rose  19a. Informant's Name/Relationship (Type, Print)  19b. Mail  | ling Address (Street and Number or Rura  | Chisley  | Los Tours State Tin Code  |
| ĭ                    | d 2 s<br>th an<br>7 ts<br>trau   |                              |  | 06 Kilburnie Cr. Fo  | ,  |   |
| a)                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Mudical Examinst must be notified at once. |                              | 20a. Method of Disposition 20b. Place of Disp  |  |  | Location - City or Town, State  |
| Baltimore,           | Pages<br>nent of I<br>int: If it   |                              | 1 Burial 2 □ Cremation 3 □ Removal from State cemetery, cre  | amatory or other place)  | 200.   |   |
| 를                    | it. Partme   |                              |  | Vet's Cemt.   Mar 2  |  |   |
| Ba                   | permit. Page<br>Department<br>Important: It<br>any injury o  |                              | NOI- IN PARTY IN   | 22. Name and Address of Facility Ste   |  |   |
|                      |  |                              | 23a. Parts. Enter the disease, or complications that caused the death. Do not en   | 001 Benning Road,  |  |   |
| μ                    |  |                              | snock, or near failure. List only one cause on each line.  | - 0  | -  | Approximate<br>Interval Between<br>Onset and Death  |
|                      | Physician  |                              | Immediate Cause (Final disease or condition resulting in death)  | THE BREAST U   | SITH 14  | 12/ASTICES NIGHTA   |
| н                    | /Medical<br>Examiner   |                              | Due to (or as a consequence of):   |  |  |   |
|                      |  | _                            | Sequentially list conditions, b.   |  |  |   |
|                      | ed sit   | Examiner                     | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury   |  |  |   |
|                      | and<br>I-tran  | хап                          | that initiated events c.  resulting in death) Last Due to (or as a consequence of):  |  |  |   |
| 60,                  | be e)<br>ician<br>buria  | E                            | 5 5 5 6 (of as a consequence of).  |  |  |   |
| 68760                | ificate be executed<br>physician and<br>as the burial-transit  | edicai                       | d  |  |  |   |
|                      | at the death certific<br>I by the attending p  | /Me                          | IF FEMALE:   |  |  | 4415-32-44-   |
| Box                  | death cert<br>e attending<br>ed for use  | lan                          |  | □Ectopic pregnancy   |  | 23d. Date of delivery  Month Day Year   |
| o.                   | the d  | Physician/M                  | 1 ☐ Yes 2 ■No 4 ☐ Pregnant at time of death 5 [ 9 ☐ Unknown 9 ☐ Unknown  | Other (specify)  |  |   |
| Д.                   | requires that the<br>een signed by th<br>hould be detache  | P.                           | Part II. Dther significant conditions contributing to death but not resulting in the t   | Inderlying cause given in Part I   | 23e Did tobacco  | use contribute to the cause of death?   |
| က်                   | uires than signed be   | 1 by                         | ,  | arradory mg daddo givoir mr arri.  | 1 □ Yes  |   |
| 0                    | w requ   | Completed                    |  |  | 1 103  | 2 2 10 0 1 10000 4 101110 111   |
| Q                    | The law<br>cate has b<br>page 2 sl   | npi                          |  |  | 24a. Was an autopsy  | 24b. Were autopsy findings available<br>prior to completion of cause of   |
| ഇ                    | £ 00   | 5                            |  |  | performed?   | death?  |
| al Re                | pa pa  | ပိ                           |  |  | 1  Yes 2   | lo 1 Yes 2 No   |
| /ital Re             | clan: Ti<br>ertificate<br>ector, pa  | Be Co                        | 25. Was case referred to medical examiner?   | 26. Place of Death   | (Check only one)   | 1 Yes 2 No  |
| of Vital Records,    | hysician: Th   | 0                            | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie   | nt 3□ DOA Other: 4★Nursing Ho  |  |   |
|                      | ing Physician: Ti  | To Be                        | examiner?  1  Yes 2 No   | nt 3□ DOA Other: 4 Nursing Ho  | (Check only one)   | 6 ☐Other (Specify)  |
|                      | landing Physician: The eath.  or: After this certificate the funeral director, pa  | To Be                        | examiner?  1   | ont 3 DOA Other: 4 Nursing Hole of 28c. Injury at Work? M 1 Yes 2 No   | n (Check only one)<br>me 5 ☐ Residence   | 6 ☐Other (Specify)  |
|                      | or Attanding Physician: The death. itactor: After this certificate in by the funeral director, pa  | To Be                        | examiner? 1  | ont 3 DOA Other: 4 Nursing Hole of 28c. Injury at Work? M 1 Yes 2 No   | n (Check only one) me 5  Residence 28d. Describe how inj   | 6 □Other (Specify) iury occurred  and Number or Rural Route Number,   |
| Division of Vital Re | or Attanding Physician<br>after death.<br>Diractor: After this certifi<br>in by the funeral director   | Certification: To Be         | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  Hospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of I | of 28c. Injury at Work?  M 1 Yes 2 No  | n (Check only one) me 5 ☐ Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta  | 6 □Other (Specify) fury occurred  and Number or Rural Route Number, te)   |
|                      | or Attanding Physician<br>after death.<br>Diractor: After this certifi<br>in by the funeral director   | Certification: To Be         | examiner?    Yes   2 No  | ont 3 DOA Cther: 4 Nursing Hold | n (Check only one) me 5 ☐ Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta  | 6 Other (Specify) iury occurred and Number or Rural Route Number, ite)  |
|                      | Hospital or Attanding Physician 4 hours after death. Funaral Diractor: After this certificially filled in by the funeral director  | edical Certification; To Be  | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat and manner stated.  | ont 3 DOA Other: 4 Nursing Hold | n (Check only one)  me 5 ☐ Residence 28d. Describe how inj  28f. Location (Street a City or Town, Sta  and due to the cause( ed at the time, date an | 6 □Other (Specify) itury occurred  and Number or Rural Route Number, ite)  (s) and manner as stated. Ind place, and due to the cause(s) |
|                      | he Hospital or Attanding Physician<br>in 24 hours after death.<br>he Funaral Diractor: After this certifi<br>pletely filled in by the funeral director   | Certification: To Be         | examiner?    Yes   2 No  | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office  th occurred at the time, date and place, nvestigation, in my opinion, death occurred.   | me 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta and due to the cause( ed at the time, date at 29d. D                  | and Number or Rural Route Number, ite)  (s) and manner as stated. and place, and due to the cause(s)  (a) the signed (Month, Day, Year) |
|                      | Hospital or Attanding Physician 4 hours after death. Funaral Diractor: After this certificially filled in by the funeral director  | edical Certification; To Be  | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat and manner stated.  | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office  th occurred at the time, date and place, nvestigation, in my opinion, death occurred.   | me 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta and due to the cause( ed at the time, date at 29d. D                  | and Number or Rural Route Number, ite)  (s) and manner as stated. and place, and due to the cause(s)  (a) the signed (Month, Day, Year) |
|                      | Hospital or Attanding Physician 4 hours after death. Funaral Diractor: After this certificially filled in by the funeral director  | edical Certification; To Be  | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat and manner stated.  | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office  th occurred at the time, date and place, nvestigation, in my opinion, death occurred.   | me 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta and due to the cause( ed at the time, date at 29d. D                  | and Number or Rural Route Number, ite)  (s) and manner as stated. and place, and due to the cause(s)  (a) the signed (Month, Day, Year) |
|                      | Hospital or Attanding Physician 4 hours after death. Funaral Diractor: After this certificially filled in by the funeral director  | Medical Certification; To Be | examiner?    Yes   Yes   No  | of 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office  th occurred at the time, date and place, nvestigation, in my opinion, death occurred.   | me 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta and due to the cause( ed at the time, date at 29d. D                  | 6 □Other (Specify) itury occurred  and Number or Rural Route Number, ite)  (s) and manner as stated. Ind place, and due to the cause(s) |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                         |  |                  | For<br>State<br>Registrar   |                            | State of Mi   | arylaric                     |                | tificate                      |                   |  |                                 | Reg. No.      | 711110                                  | 11541  |
|-------------------------|--|------------------|---|----------------------------|---|------------------------------|----------------|-------------------------------|-------------------|--|---------------------------------|---------------|---|--|
| F                       | Physicia   | an               | 1. Decedent's Name (First, PAULINE  |                            | •   |                              |                |                               |                   |  | 2. Date of De<br>Month<br>March |               | 200 <sup>Y</sup> 8ar                    | 3. Time of Death 1610 M                          |
|                         | /Medic   | al               |   |                            |   |                              |                | 4b City To                    | own orl           | ocation of Death                       | rai cii                         |               | County of Death                         |  |
| )                       | Examin   | er               | 4a. Facility Name (If not ins   |                            |   | C HO                         | ME I           |                               |                   | CRLY                                   |                                 |               | RINCE (                                 |  |
|                         | Funeral  |                  | 5. Social Security Number   | 6. S                       |   |                              | nst birthday)  | If Under 1                    | Year              | If Under 24 Hrs.                       | 8. Date of Bir                  | th            | 9 Birth                                 | nplace (State or Foreign                         |
| ı                       | Director   |                  | 423-72-737  | 6                          | □M 2K□F   | 83                           | Yrs.           | Months [                      | Days              | Hours Min.                             | 11/11                           | 7192          | 24 Ala                                  | abama  |
|                         | pun ,  |                  | Usual Residence of Deced<br>10a. State 10b. 0   | ent<br>County              |   | 10c. City.                   | Town or Lo     | cation                        |                   |  |                                 |               |   | 10d. Inside City Limits                          |
|                         | faryla<br>f shored<br>ed at  | ō                | DC  | rounty                     |   |                              |                | ngton                         |                   |  |                                 |               |   | 1XYes 2□No                                       |
|                         | the N<br>28a-<br>notif   | rect             | 10e. Street and Number  |                            |   | , v                          | Vasiii         | 10f. Zip C                    |                   |  |                                 | 10g. Citi     | zen of What Co                          | untry?   |
|                         | 3a or  | Funeral Director | 715 4th   | Stre                       | at NF   |                              |                | 2                             | 2000              | 12                                     |                                 | US            | 3 A                                     |  |
|                         | death<br>ms 2  | ner              | 11. Marital Status  | DCIC                       | 12. Was Decedent<br>Armed Forces?                           |                              | 3. 13.         |                               |                   | panic Origin? (Sp<br>, Mexican, Puerto | pecify Yes or No                |               | 14. Race - Amer<br>Black, White         |  |
| Maryland 21215-0036     | be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at         | Ď                | 1 □ Never Married 2[<br>3 🕱 Widowed 4 □ Di  |                            | 1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates:               |                              |                | I □ Yes 2                     |                   | Specify:                               | r nouri, oto.)                  |               | Specify: Bla                            |  |
| Š<br>Ž                  | 72 ho<br>natur<br>ilical   | Completed        |   | ecedent's Ec               | ducation<br>ade completed)                                  |                              | 16a. Deced     | lent's Usual (                | Occupat           | tion<br>uring most of work             | king                            | 16b. Ki       | nd of Business/I                        | Industry   |
| 7                       | ithin ne.  | mple             | Elementary/Secondary (  | 0-12)                      | College (1-4or  | 5+)                          |                | oo not use<br>memak           | -                 |  |                                 | 0.1           | vn home                                 | ,  |
| 2                       | iled w<br>Hygie<br>her ti  | Ö                | 6th grad  17. Father's Name (First, M   |                            |   |                              | 110.           | memax                         |                   | 18. Mother's Nam                       | ne (First, Middle               | 1             |   |  |
| anc                     | be d d   | ) Be             | Jimmy Hur   |                            | <i>'</i>  |                              |                |                               |                   |  | a Harr                          |               | ourname)                                |  |
| Ž                       | 2 should be<br>and Menta<br>is marked<br>aumatic ev  | 2                | 19a. Informant's Name/Re  |                            | Type. Print)  |                              | 19b. Maitir    | ig Address (S                 | Street ar         |  |                                 |               | r Town, State, Z                        | Zip Code)  |
|                         | nd 2 state at trau   |                  | Annie Tho   |                            |   | er                           | 16             | 18 Fo                         | res               | t Park<br>Le, MD                       | Dr.<br>2074                     |               |   |  |
| ē,                      | is 1 and 2<br>of Health<br>Item 27<br>other tra  |                  | 20a. Method of Disposition  |                            |   | 20b. Pl                      | emetery crer   | natory or oth                 | er place          | )                                      | Date                            | 20c. Lo       | ocation - City or                       | Town, State                                      |
| Ë                       | 0 0  |                  | 1X Burial 2 ☐ Crem<br>4 ☐ Donation 5 ☐ O  |                            |   | G1 G                         | over<br>optis  | Primi<br>t Chu                | tiv               | e 03/2                                 | 2/2008                          | The           | omastor                                 | n . A 1  |
| Baltimore,              | permit. Pag<br>Department<br>Important: I<br>any injury o  |                  | 21. Signature of Funeral S  | iervice Licer              | Take  | 1007                         | 22             | 2. Name and                   | Address           | of Facility R                          | EESE P                          | ROFE          | ESSIONA                                 | AL FUNERAL<br>,DC 20010                          |
|                         |  |                  | 23a. Part1. Enter the dise  | ase, or com                | plications that cause                                       | d the death                  |                |                               |                   |  |                                 |               | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Approximate<br>Interval Between                  |
|                         | Physician  |                  | Immediate Cause (Final disease or condition   | e. List Offiy              |   |                              | Cance          |                               |                   |  |                                 |               |   | Onset and Death  1 yr.                           |
| 7                       | /Medical   |                  | resulting in death)  Due to (or as a consequence of):   |                            |   |                              |                |                               |                   |  |                                 |               |   | , y ± •  |
|                         | Examiner   |                  | Sequentially list conditions  |                            | b   |                              |                |                               |                   |  |                                 |               |   |  |
|                         | D #  | iner             | Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Ursease or injury | te 👤                       | Due to (or as   | a consequ                    | ence of):      |                               |                   |  |                                 |               |   |  |
|                         | ecute<br>and<br>I-trans  | Examiner         | that initiated events<br>resulting in death) Last   |                            | c<br>Due to (or as  | a consequ                    | ence of):      |                               |                   |  |                                 |               |   |  |
| 60,                     | rificate be executed g physician and as the burial-transit   | alE              |   | - (                        |   |                              | ,              |                               |                   |  |                                 |               |   |  |
| 68760                   | tificate<br>ng phys<br>as the  | ledical          |   |                            | a   |                              |                |                               |                   |  |                                 |               |   |  |
|                         | n certi  |                  | IF FEMALE:<br>23b. Was decedent pregn   | ant                        | 23c. If yes, outcome  | pf pregnai                   | ncy            | 75-4                          |                   |  |                                 |               | 23d. Date of del                        | ivery  |
| Vital Records, P.O. Box | tending Physician: The law requires that the death certeath. tor: After this certificate has been signed by the attendin the funeral director, page 2 should be detached for use | Physician/N      | in the past 12 month<br>1 ☐ Yes 2 ☑ No  |                            | 1⊡Live birth<br>4⊡Pregnant a<br>9⊡Unknown                   |                              |                | ⊒Ectopic preg<br>⊒Other (spec |                   |  |                                 |               | Month                                   | Day Year   |
| 0.                      | at the<br>by th  | hys              | 9 ☐ Unknown   |                            |   |                              |                |                               |                   |  |                                 |               |   |  |
| Ś                       | res th<br>igned  | by               | Part II. Other significant of   | conditions o<br>psis       | contributing to death t                                     | out not resu                 | Iting in the u | nderlying cau                 | use givei         | n in Part I.                           |                                 |               |   | o the cause of death?  robably 4 □Unknown        |
| 000                     | requii   | ted              |   | -                          |   |                              |                |                               |                   |  |                                 | 165 2         | ]                                       | obably 4 Donkhown                                |
| ဒ္ဓင                    | elaw<br>hasb<br>e2sl   | Completed        | An  | emia                       |   |                              |                |                               |                   |  | 24a. Was                        |               | 24b. Were au<br>prior to<br>death?      | utopsy findings available completion of cause of |
| a                       | n: The   |                  |   |                            | Vaginal   | l Fis                        | tula           |                               |                   |  | 1□ Yes                          | 2 <b>X</b> No |   | 2 □ No   |
| ₹                       | siciar<br>certif   | Be c             | 25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No   | nedical                    | Hospital: 1 ☐ Inpati  | ont 201                      | EB/Outpotion   | ** 3□ DOA                     |                   | 26. Place of Dea                       |                                 |               | л Понь - : /O                           | -16.1  |
| o                       | Attending Physician: r death. ector: After this certifics by the funeral director, I   | <u>۲</u>         | 1 ☐ Yes 2 No<br>27. Manner of Death   |                            | 28a. Date of Inj  | ury                          | 28b. Time o    |                               | c. Injury<br>Work |  | 28d. Describe                   |               | 6 ☐Other (Spe<br>ry occurred            | CITY)  |
| O                       | nding<br>th.<br>r: Afte<br>e fune  | tior             | 1 X Natural 5 ☐<br>2 ☐ Accident   | Pending<br>investigation   | ( <i>Month, Da</i><br>n                                     | ay Year)                     | Injury         | М                             |                   | ?<br>′es 2 □ No                        |                                 |               |   |  |
| Division or             | # P 0 >  | ifice            |   | Could not be<br>determined | 200. Flace of III   | jury - At ho<br>tc. (Specify | me, farm, str  | eet, factory,                 | office            |  | 28f. Location<br>City or To     | (Street ar    | nd Number or Ru                         | ural Route Number,                               |
| Ö                       | rs after al Dir  | Certification:   |   |                            | Danding, 6  |                              |                |                               |                   |  | 5, 6, 70                        | , जावार       |   |  |
|                         | To the Hospital or Attentwithin 24 hours after death To the Funeral Director:  | Medical (        |   |                            | nysician: To the best<br>miner: On the basis<br>and manners | of examigat                  |                |                               |                   |  |                                 |               |   |  |
|                         | To the within 2 To the comple  | Mea              | 29b. Signature and little of  | certifier                  | and manner s  | LLIEU.                       |                | 290                           | License           | number                                 |                                 | 29d. Da       | te signed (Mont                         | th, Day, Year)                                   |
|                         | ٦€٤  |                  | · W   | N                          | MM  | yy                           |                |                               | 01                | 6273MD                                 |                                 |               | 3/11/08                                 |  |
| 0                       |  |                  | 30. Name and address of   | person who                 | completed cause of  | Teath (Item                  | 23a) (Type,    | Print)                        |                   |  |                                 |               |   |  |
| 1                       |  |                  | Revath  | y Mui                      | rthy 61   | 30 La                        | andov          | er Rd                         | .,                | Cheve                                  | rly, M                          | D             |   |  |
|                         | Sta<br>Registi   |                  | 31. Date filed (Month, Day<br>MAR 2 1 20  |                            | 32. Regist  | rar's Signa                  | ture           |                               |                   |  |                                 |               |   |  |
|                         | riegisti   | CIT I            | HINTILY OF T PR   |                            | MARINE J. JU  | - A 100 PM                   |                |                               |                   |  |                                 |               |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lena Theresa Brown March 8, 2008 0800 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Brook Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye 03/25/1939 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 F 577-56-4799 68 Director South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 No MD Mantgarery Silver Spring Director 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 12325 New Hampshire Avenue 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Federal Covernment permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked ofth any injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie E. Cook Lena Akers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven C. Gaskins - Son 5125 Vest Lane; Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 03/19/2008 Landover, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Freeman Funeral Services 6 Funeral Service License 21. Signatu 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part1 Enter the disease, or compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only or - c luse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed physician and s the burial-transit Box 68760. Physician/Medical attending pl IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 | Pending 1 □ Yes 2 □ No death. investigation the 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide ò Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) PARKWAY GREETEBELT MARYLANED 20720

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 1 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) April 2, 2008 Physician Kim 7:00 am<sup>M</sup> Robin Biser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 701 Maxwell Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 XF 218-72-3819 48 Director Mary Land Apr 4, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov iral", or items 23a or 28a-f shov Examiner must be notified at Maryland Frederick Frederick 1 XIYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 701 Moaxwell Avenue Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White à If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Never Worked 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eury Sandra Ellen John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Sandra Eury, Mother 701 Maxwell Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 5, 2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21. Signature f Funeral Service License Part1. Enter the dis M00706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 70445 UROSEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as 1 IF FEMALE for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ Cholecystites 1 🗌 Yes 2 No 3 Probably 4 Unknown EDEMA Completed Decubitus VICERS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No te has t 24a. Was an autopsy perform 1□ Yes 2☑No certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 📋 Inpatient 2 ER/Outpatient 3□ DOA ဥ After this 27. Mayor of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. al Director: After Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

M.D., 1564 Opossumtown Pike, Frederick, Maryland 21702

usuu

2. Registrar's Signature

30. Name and ad ess of person who completed cause of d th (Item 23a) (Type, Print)

Eugene B. Casagrande,

APR 0 9 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 **Physician** APRIL 2 7:03 p<sup>M</sup> THOMAS GARY BLACKSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Chestertown Kent Chester River Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 1**X** M 2 □ F 74 Feb 24 1934 Maryland 218-28-5075 Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No MD Kent Chestertown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt G-204 101 Morgnec Rd. 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1953 If Yes, Give Year or Dates: -1955 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify. 9 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Military Training College (1-4or 5+) Elementary/Secondary (0-12) & Testing Base Locksmith 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lipuy or other traumatic event, one. 17. Father's Name (First, Middle, Last) Be Thomas Oscar Blackson Mildred Anna Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620 19a, Informant's Name/Relationship (Type, Print) Cynthia Blackson (wife) 101 Morgnec Rd. Apt. G-204 Chestertown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kent Cremation Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4/3/08 Smyrna, DE. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Sc
118 West Cross St. Galena, MD. 21635 21. Signature of Funeral Service Licen Schaech M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high rt failure. List only one cause on each line. Approximate Interval Between Immediate Caux (Final disease or caraction resulting in death) MO, **Physician** Name ce ) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed k 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 ASCAD No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital □ Inpatient 2 □ ER/Outpatient 3 □ DOA ၉ After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attendi nours after death. neral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral D completely filled in 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Frederick Delboy,

29b. Signature and title of certific

32. Registrar's Signature

and manner stated.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S

29c. License number

6602 Church Hill Rd. Chestertown, MD. 21620

29d. Date signed (Month, Day, Year) 3)08

DHMH 17 Rev 1/2001

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. Registrar's Signature

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31. Date filed (Month, Day, Year)

APR 09

N CHAPLES ST. SUITE 209 BALTIMERE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:10 p M Sylvania Chisley March 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 ☐ M 2 🔼 F Months Days Director North Carolina 577-32-6628 September 24,1927 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a 13303 Brackley Road 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Married Ь 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced 'natural", Year or Dates: Black Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Percy Taylor Mary C. Sutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Chisley - Son 8905 Remington Place, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any injury or ot 1 Na Burial 2 ☐ Cremation 3 Na Removal from State 4 Donation 5 Dother (Specify) Arlington National Cemetery 04/02/2008 Arlington, Virginia 21. Signature of Funeral Service/Ligense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 eart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner UTI Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine death certificate be executed Aspiration Pneumonia that initiated events resulting in death) Last and Due to (or as a consequence of): burialphysician s the buria Physician/Medical attending p as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4⊡Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 🔼 No 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 CVA 1 Yes 2 No 3 Probably 4 KUnknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Anemia has autopsy performe certificate Renal Insufficiency 1 Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 🔀 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) To the Hosping. within 24 hours after death.
To the Funeral Director: Aft 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature apo 29d. Date signed (Month, Day, Year)

State Registrar

MAR 26 2008

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Box 68760.

P.O. 1

Division or Vital Records,

Abdul Munim, M.D., 10724 Little Patuzent Pkwy., Suite 200, Columbia, Maryland 21044

D58861

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs 03/05/1951 1 □ M 2 □ F 214-58-4355 57 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Calvert. Huntingtown 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 270 Kyler Road 20639 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Private If item 27 Is marked other or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alnutt Levi Chase, Sr. Ruby Janes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Rice — Sister 260 Kyler Road/ P.O. Box 157; Huntingtown, MD 20639 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) Patuxant U.M. Church Cem. 3 Removal from State 03/22/2008 Huntingtown, Maryland 21. Signature o Funeral Service Licens 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 Approximate
Interval Between
Onset and Death the disease, or comean failure. List only tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the di-shock, ox heart fail Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 W No Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nnknown Obesin 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tes 2**1**0 No 1 patient ဥ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760, Fo the Hospital or Attending Physician:

State

DHMH 17 Rev 1/2001

Registrar

Date filed (Month, Day, 2008

30. Name and address of person who complete

29b. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2008 12210 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Momico PMSULA SALISBUM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day Year) Age (In yrs. last birthday) Security Number 6 Sex **Funeral** Months Days Hours Min. 1 □ M 2 🖸 F 238-40-2105 Usual Residence of Decedent 38-40-2103 Director 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 28a-f show 1 ☐ Yes 2 No other traumatic event, the Medical Examiner must be notified Funeral Director DMIG 3 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number or items 23a or 21809 icomic 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1□Yes 2☑No Maryland 21215-0036 Specify Specify: Blace þ 3 ☐ Widowed 4 ☐ Divorced "natural", Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brd 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic ever 1ac James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State Wia Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3128 10 lindley chaplel 4 Donation 5 ☐ Other (Specify) . Signature of F eral Service Licensee 22. Name and Address of Facility 917 W Isabella struct Smith MO 250 Bennie Freneral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oni andia /Medical Due to (or as a consequence of): Examiner onco 4804 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for each number of Physician/Medical Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of Box 68760, attending physician for use as the buria a beto IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the s 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2 INO Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA P After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie caw py 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 25 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 1923 M Alberta Coon 21 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SAISBULL Womici 910ND1 TENINSULA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF **Director** 262-38-7858 91 May 1, Georgia Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 21801 USA 27479 Edgewood Circle filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No ģ 3 ☐ Widowed 4 → Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7th Lab Technician Campbell Soup, Inc. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any in]ury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy Battle William 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20735 Diana Chandler-Banks/ niece 5909 Butterfield Drive, Clinton, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem. Gdns 03/29/2008 Hebron, Maryland 4 ☐ Depation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL, P.A. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPER ANEIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending p IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1☐ Yes ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ASCVO cate has been signated by page 2 should by 1 | Yes 2 | No 3 | Probably 4 | Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The 2 1No 2 14 1/10 1 ☐ Yes Division or Vital 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t al or Attending P after death. I Director; After I d in by the funera Certification: 5 Pending investigation **U** ■ Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar DGE

EASTERN

32. Zegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

63199

DR

SALISBURY.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:55 PM **EDWARD** CHIASSON 2008 22 J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbure Coastal Hospice out the Lake Wicomico 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 XM 2□ F CANADA 547-88-1874 1940 22, Director Usual Residence of Decedent the Maryland 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 19975 36191 LIGHTHOUSE ROAD CANADA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MODEL LIGHTHOUSE Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR 8 BUILDER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOREAU CHIASSON ADELIA **GERVAIS** ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 13055 SOUTH TWINSTAR DR., VAIL, ARIZONA 85641 MANNDE A. DUGAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/24/08 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA: 22. Name and Address of Facility 21. Signature of Funeral Service License HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 lart1 Inter the discase, or complications that cluse in shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** MRTASTATIC ROSTATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy performed 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend s after death if Director: / 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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Huchy

31. Date filed (Month, Day, Year)

HOSPICE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 5 2008

COASTAL

0005 8410

02-22-08

P.O BOX 1733 SALISBURY NO 21802

|  | For  |   | Department of H   | lealth and I                            |  |                             | gible.                                      | 1155   |
|--|--|---|---|---|--|-----------------------------|---|--|
| _]   | State Registrar  |   | Certificate of  | Death                                   | 1.                                       | Reg. No.                    |   | 2. Time of Dooth                                   |
| ın   | 1. Decedent's Name (First, Middle, Last)   | COLLING   |   |   | 2. Date of Dea<br>Month                  | Day                         | Year  | 3. Time of Death                                   |
| al _   | DAVIS EDWARD   | COLLINS   | 4h City Town o  | r Location of Deatl                     | 107                                      | 4c. Co                      | unty of Deat                                | 1.131  |
|  | 4a. Facility Name (If not institution, give street and n  COUSTAL HOSPICE AT  5. Social Security Number  6. Sex  1 1 M M 2 F | 7. Age (In yrs. last bir  | e Salis<br>thday) If Under 1 Year<br>Months Days                      | If Under 24 Hrs. Hours Min.             | 8. Date of Birt                          | h<br>v, Year)               | 9. Birti                                    | nplace (State or Foreiguntry)                      |
| _ L  | 218-40-4324  | 04  | Yrs.  |   | MAY 2,                                   | 1943                        | WEST  | VIRGINIA   |
|  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Tow  | n or Location   |   |  |                             |   | 10d. Inside City Limit                             |
| 0  | DELAWARE SUSSEX  | FRANK   | FORD  |   |  |                             |   | 1 □Yes 2X N  |
| × 1  | DELAWARE   SUSSEX  10e. Street and Number  | TIGHT   | 10f. Zip Code   |   |  | 10g. Citizer                | of What Co                                  | untry?   |
|  | 34535 RICKARDS ROAD  |   | 199   | 45                                      |  | USA                         | A   |  |
| Funeral  |  | cedent Ever in U.S.   | 13. Was Decedent of I   | lispanic Origin? (S                     | pecify Yes or No                         | . 14.                       | Race - Ame<br>Black, White                  | ,  |
| þ  |  | s 2 □ No<br>Give<br>Dates:  | 1 □ Yes 2 <b>X</b> □ No   | Specify:                                | ,  | Sį                          | pecify.WHI                                  | TE   |
| etec   | 15. Decedent's Education<br>(Specify only highest grade completed  |   | <ul> <li>Decedent's Usual Occu<br/>(Give kind of work done</li> </ul> | during most of wo                       | rking                                    | 16b. Kind                   | of Business/                                | Industry   |
| Completed  |  | (1-4or 5+)  | `life. DO NOT use retire  | ,                                       |  | CM A MI                     | מישטיים                                     | TET ATTATOTE                                       |
|  |  | 1 COR   | RECTIONAL O   |   | me (First, Middle,                       |                             |   | ELAWARE  |
| Be   | 17. Father's Name (First, Middle, Last)  |   |   |   | , , , , , , ,                            | manaon oo                   |   |  |
| ္ ၂  | EDWARD COLLINS   | 100   | b. Mailing Address (Stree   |   | OSBORNE                                  | er City or T                | own State                                   | Zin Code)  |
|  | 19a. Informant's Name/Relationship (Type. Print)   |   | 535 RICKARD   |   |  |                             |   |  |
| 10   | LINDA L. COLLINS/WIFE  20a. Method of Disposition  |   | of Disposition (Name of   | D 1021D, 2                              | Date                                     |                             | tion - City or                              |  |
|  | 1 XBurial 2 ☐ Cremation 3 ☐ Removal fro<br>4 ☐ Donation 5 ☐ Other (Specify)  | m State cemete  | ery, crematory or other pla<br>RE VETERANS                            |   | /27/08                                   |                             |   | DELAWARE   |
| ı  | 21. Signatur of Fun ral Sorvice Licen  | 1   | 22. Name and Addr   |   | HOME, SE                                 | LBYVI                       | LLE, D                                      | E 19975  |
| 35 X   |  | ARCINO  | MA C  |   |  | rrest,                      |   | Approximate<br>Interval Between<br>Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or light, y that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C  |  |   |   |   |  |                             |   |  |
| Physician/Medica   | in the past 12 months?   | outcome pf pregnancy<br>re birth 2 □ Fetal deat<br>egnant at time of death<br>known | th 3□Ectopic pregnan<br>5□ Other <i>(specify)</i>                     | су                                      |  | 23                          | d. Date of de<br>Month                      | livery<br>Day Year                                 |
| by   | Part II. Other significant conditions contributing to  | death but not resulting   | in the underlying cause g   | iven in Part I.                         |  | tobacco use<br>Yes 2□       |   | o the cause of death?<br>Probably 4 ∐Unkno         |
| Completed  |  |   |   |   | 24a. Was<br>auto<br>perf<br>1∐ Yes       |                             | 24b. Were a<br>prior to<br>death?<br>1 ☐ Ye |  |
| Be   | 25. Was case referred to medical examiner?   |   |   | thor                                    | eath (Check only                         |                             |   |  |
| 은  |  |   | Sutpatient 3 DOA  | 4 ∐ Nursing                             | Home 5 ☐ Res                             |                             |   | ecify)   |
| on:  | Natural 5 Pending (N   | ate of Injury 28b.<br>fonth, Day Year)  | Time of 28c, In W   | ury at<br>ork?<br>⊒Yes 2 ⊒No            | Zou. Describe                            | now injury                  | Cocalled                                    |  |
| 27. Manner of Death    Antural   S   Pending investigation   S   Suicide   A   Homicide   See. Place of injury - At home, farm, street, factory, office   See. Place of injury - At home, farm |  |   |   |   |  |                             |   | Rural Route Number,                                |
| Medical C  | 29a. Certifier the Certifying Physician: To (Check only one) Medical Examiner: On the and m                                  | the best of my knowledge basis of examination an                                    | ge, death occurred at the<br>and/or investigation, in m               | time, date and pla<br>opinion, death oc | ce, and due to the<br>curred at the time | e cause(s) a<br>e, date and | and manner a<br>place, and di               | as stated.<br>ue to the cause(s)                   |
| ₩  | 29b. Signature and title of certifier  |   | 29c. Lice   | nse number                              |  | 29d. Date                   | signed (Mo                                  | nth, Day, Year)                                    |
| 1  | 1  | 3   | De  | 05841                                   | 0  | 07                          | 2-21  | -08  |
|  | 30. Name and address of person who completed of  | ause of death (Item 23a   | i) (Type, Print)  |   |  |                             |   |  |
|  | GHULAM WARIS COAS  | TAL HOSE<br>2. Registrar's Signature  | PICA PO   | BOX 17                                  | 3) SA2                                   | 45Bu                        | Ryu   | D 2/80   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:06 AM BETTY **JEAN** CROWLEY APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner La PLATA CHARLES CIVISTA MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 √5 224-70-5389 Director 61 JAN.17,1947 PENNSYLVANIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director MD CHARLES HUGHESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7555 SERENITY DRIVE 20637 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married ò 1 ☐ Yes 2 ☐ No Specify: WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) AIRLINE TRANSPORTATION FLIGHT ATTENDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD J. CROWLEY CATHERINE LONG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE SCHENKMAN/SISTER 7555 SERENITY DR. HUGHESVILLE, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) PRIL 2008 3 Removal from State ST.MARY'S CEMTRY. SARTWELL, PA 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service License M00641 5635 WASHINGTON AVE. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infinishing cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 → No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 14Inpatient 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52289 12008

) DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

11855 HOLLY LANE, SUITE 107, WALDORF, MD 20601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

M.D.

2008

NALIN MATHUR,

31. Date filed (Month, Day, Year)

APR 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Dorothea Marie Dempsey March /Medical 20, 2008 6:10 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1□M 21□F Director 92 579-48-6199 May 6, 1915 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e with r items 23a o 2405 Sheraton Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinor must Funeral USA . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 📢 o Specify þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Compositor Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Haydon Ula Gladys Dunn ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Dempsey, III/Son 2405 Sheraton Drive, Wheaton, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 26 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2008 Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses AnneMark 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Car 110—1:11u > nary Arrest
Due to (or as a consequent of): /Medical Examiner b. Acute Stroke Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown certificate has been signed rector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmea≀ 2⊟ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1

Inpatient 2 ■ ER/Outpatient 3 ■ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural (Month, Day Year) spital or Attendi nours after death. neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

.\_\_\_\_

DHMH 17 Rev 1/2001

State 31. Date f
Registrar

31. Date filed (Month, Day, Year)

MAR 26

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Irina Ruban, MD 1500 Forest Glen Road, Silver Spring, MD 20910

3. Registrar's Signature

D63343

March 20, 2008

Registrar

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Regierar's Signature

Hanu

MAR 24

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                |   |               | 1- For Amend Items 25,27,28   | aryland /         | Depa<br>r me<br>Cei | artment of Heal<br>1878 04 30<br>1878 01 Dea        | th and M<br>208dhb          |  |                   | 18                     | 56   |
|----------------|---|---------------|---|-------------------|---------------------|---|-----------------------------|--|-------------------|------------------------|--|
|                | Physici   | an            | Decedent's Name (First, Middle, Last)   |                   |                     |   |                             | <ol><li>Date of Dear<br/>Month</li></ol>   | Day               | Year                   | 3. Time of Death                               |
|                | /Medi   |               | JOHN PATRICK  |                   | DOUG                | HERTY   |                             | MARCH  |                   | 800                    | 2:45 A <sup>M</sup>                            |
|                | Examir  | ier           | 4a. Facility Name (If not institution, give street and number,  | )                 |                     | 4b. City, Town, or Loca                             | ation of Death              |  | 4c. County        |                        |  |
|                | -   |               | 28385 OLD EDEN ROAD  5. Social Security Number 6. Sex 7. Ag   | ge (In yrs. last  | birthday)           | EDEN If Under 1 Year   If U                         | Inder 24 Hrs.               | 8. Date of Birth   |                   | OMIC<br>9. Birthol     | lace (State or Foreign                         |
|                | Funeral<br>Director   |               | 164-26-6672 1⊠M 2□F   | 77                | Yrs.                |   | ours Min.                   | 8. Date of Birth<br>(Month, Day)<br>MAR • 13   | Year)<br>1931     | Coun                   | (ry)<br>LAND                                   |
|                | D   |               | Usual Residence of Decedent   |                   |                     |   |                             |  |                   |                        |  |
|                | show  | _             | 10a. State 10b. County  | 10c. City, To     |                     |   |                             |  |                   | 10                     | 0d. Inside City Limits 1   Yes 2  No           |
|                | Ba-f  | Director      | PA DELAWARE   | ļ A               | ASTON               |   |                             |  | 0 000 000         |                        |  |
|                | with the  | 吉             | 10e. Street and Number  |                   |                     | 10f. Zip Code                                       |                             | 1  | 0g. Citizen of V  | vnat Coun              | try r  |
|                | ns 23   | eral          | 180 BISHOP DRIVE  11. Marital Status 12. Was Decedent   | Ever in U.S.      | 13. 1               | 19014 Was Decedent of Hispan                        | nic Origin? (Spe            | cify Yes or No-  | USA<br>14. Rac    | e - America            | an Indian,                                     |
| 15-0036        | be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or itams 23a or 28a-f show event, the Medical Exercipat mast be rediffed at   | by Funeral    | Armed Forces  1 Never Married 2 Married 1 Yes 2 M  3 Widowed 4 Divorced Year or Dates:                                  | ?<br>No           |                     | f Yes, specify Cuban, Me                            | exican, Puerto i<br>necity: | Rican, etc.)   |                   | k, White,              |  |
| Š              | 72 ho   | Completed     | 15. Decedent's Education (Specify only highest grade completed)   | 16                | 6a. Dece            | lent's Usual Occupation<br>kind of work done during | a most of working           | 10   | 16b. Kind of Bu   | siness/Ind             | lustry   |
| 7              | ithin | nple          | Elementary/Secondary (0-12) College (1-4or  | 5+)               | life.               | DO NOT use retired)                                 | g most or worki             | <i>'</i> 9   |                   |                        |  |
| 2              | filed within<br>Hygiene.<br>Ither than "  |               | 12  |                   |                     | INSPECTOR   | Marsha a Marsha             | (Final 44)-41-41-41-41-41-41-41-41-41-41-41-41-41-   | NUCLEA            |                        | ER   |
| Maryland       |   | Be            | 17. Father's Name (First, Middle, Last)   | 37                |                     | 18.1  |                             | (First, Middle, I  |                   |                        |  |
| Ž              | d 2 should be<br>th and Menta<br>7 is marked<br>traumatic ev  | ဥ             | HUGH DOUGHERT  19a. Informant's Name/Relationship (Type, Print)   | _                 | 9h Mailir           | a Address (Street and N                             | MARY                        |  | GARRI             |                        | Code)  |
| <u>S</u>       | 12:<br>h ar<br>7 is   |               | DEBORAH WASHINGTON/DAUGHTE  | 1                 |                     | OLD EDEN R  |                             |  |                   |                        | ,  |
| ġ,             | Hear Hear   |               | 20a. Method of Disposition  | 20b. Place        | of Dispo            | sition (Name of natory or other place)              |                             |  | 20c. Location -   |                        | wn, State                                      |
| altımore,      | Pages<br>nent of<br>int: If it<br>iry or o  |               | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)                                      | •                 | -                   | FT CEMETERY   | 3/28/                       | 08   | LYNWOOD           | , PA                   |  |
| Balt           | permit. Pages<br>Department of<br>Important: If it<br>any injury or c   |               | 21. Signatura I Fur Aral Service Licens   |                   |                     | Name and Address of I                               |                             | ME, SELI   | BYVILLE           | , DE.                  | 19975  |
|                |   |               | 23a. Part : Enter the disease, or complications that cause shock, or heart failure. List only one cause on each         | d the death. D    | _                   |   |                             |  |                   |                        | Approximate<br>Interval Between                |
|                | Pnysician   |               | Immediate Cause (Final disease or condition   | =                 | cz                  | e Parkins   | - 10                        | 7-   |                   |                        | Onset and Death                                |
|                | /Medical  |               | resulting in death)   | a consequenc      | ce of):             | e parking   | 011.2                       | 3.1  | 4.1               | 5                      | 2763   |
|                | Examiner  |               | Sequentially list conditions, b.  |                   |                     |   | ~ 1                         |  | on 1170           |                        |  |
|                | sit ad  | iner          | if any, leading to immediate  | a consequenc      | ce of):             | 1   | 1//                         | 1 Vanie  | DICAL EXAMINATION |                        |  |
|                | and<br>I-tran   | Examiner      | Cause (Disease of injury that initiated events c  | a consequence     | ce of):             |   | - ON                        | PARDY BY ME  |                   |                        | <del></del>                                    |
| 209/8          | icate be executed<br>physician and<br>s the burial-transit  |               | ·   |                   | ,                   | (   | CENTRY                      | 1  |                   |                        |  |
|                |   | edlcal        |   |                   |                     |   |                             |  |                   |                        |  |
| . Box          | The law requires that the death certific the has been signed by the attending plage 2 should be detached for use as to a signed.  | Physician/M   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | 2 Fetal dea       |                     | Ectopic pregnancy Other (specify)                   | T                           |  | 23d. Dat<br>Mo    | e of delive<br>nth     | ry<br>Day Year                                 |
| л<br>О         | at the de<br>d by the a<br>etached t  | Phy           | 9 🗆 Unknown   |                   | a la Maria          | - d- 4  | D- 41                       | 23a Did to   |                   | ributo to th           | o cause of death?                              |
| Ś              | w requires that<br>feen signed be<br>chould be deta   | ρ             | Part II. Other significant conditions contributing to death I   | out not resulting | g in the u          | nderrying cause given in i                          | Рап I.                      |  |                   |                        | e cause of death? ably 4 XUnknown              |
| Vital Records, | requ  | Completed     | C/ / / / //   | 1 rockp           | nall                | <i></i>   | <del> </del>                | and the same of th |                   |                        |  |
| ě              | has<br>has  | Id<br>Id      | Jub dural Itema t   |                   | 2 .                 |   |                             | 24a. Was a autops perform  | y r               | prior to con<br>leath? | osy findings available<br>apletion of cause of |
|                |   |               | Silateral fleural 25. Was case referred to medical  | E +6              | US10.               |   |                             | 1 ☐ Yes  | 2 ⊠ No 1          | Yes                    | 211 No   |
| 5              | ysicial<br>is certi<br>directo  | o Be          | examiner?  1 X Yes 2 No Hospital: 1 Inpati  | ent 2 DER/        | Outpatien           | Othor   |                             | (Check only on<br>ne 5⊠Reside  |                   | er (Specifi            |  |
| ō              | g Phys<br>er this<br>eral di  | n To          | 27. Manner of Death 28a. Date of Injury   |                   | p. Time of          |   |                             | 8d. Describe h   |                   |                        | ,  |
| 0              | ath.<br>r: After I  | atlo          | 2 Accident investigation Unknown  | ប <sub>្រា</sub>  | Injury<br>Inknov    | VINM 1 ☐ Yes  | 2€ No                       | Multip   | le Fall           | S                      |  |
| Division       | To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certification and the funeral director, and the funeral director,   | Certification | 4 Homicide determined huilding e  | to (Specific)     | , farm, str         | eet, factory, office                                | - 1.                        | City or Town   | n, State)         | er or Rura             | l Route Number,                                |
| _              | pital purs a aral Dilled i  |               | 29a. Certifier 1 Certifying Physician: To the best  |                   | tan dont            | a command at the time de                            |                             | Unknown  |                   | anor as st             | atod   |
|                | 24 hc<br>24 hc<br>a Fun<br>etely i  | Medical       | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner si | of examination    |                     |   |                             |  |                   |                        |  |
|                | To th<br>within<br>To th  | Me            | 29b. Signature and title of certifier   |                   |                     | 29c. License num                                    |                             | 2  | 9d. Date signed   | (Month, I              | Day, Year)                                     |
| ,              | 1.0   |               | ) - ( ) h   | 10                |                     | 029   | 4986                        |  | 3/25              | 108                    |  |
| 1              | . dr  |               | 30. Name and address of person who completed ause of  |                   | a) (Type,           | Print)  | 1                           |  |                   |                        |  |
|                |   |               | Robert J Reilly   |                   |                     | 560 Kiv   | erside                      | Dr. S  | Dalisbu           | ing                    | MD 2180  |
|                | Sta<br>Registi  |               | 31. Date filed (Month, Day, Year) 32. Refish  | rar's Signature   |                     | beck  |                             |  |                   |                        |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Michael Anthony DeGirolamo, Jr. April 2008 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Director 70 10/30/1937 173-30-3476 Pennsvlvania Usual Residence of Decedent 10d. Inside City Limits 10c. Cify, Town or Location 10b. County r 28a-f show notified at 1 Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 2508 Shelley Circle Unit 3B 21702 filed within 72 hours after death v Hygiene. Funeral United States 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than the Me Elementary/Secondary (0-12) College (1-4or 5+) consultant/engineer electrical marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be to Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve Michael Anthony DeGirolamo, Sr. Rose Degilio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Shelley Circle, 3B, Frederick, MD 21702 of Disposition (Name of Date 20c, Location - City or Town, State Carol DeGirolamo Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 04/3/2008 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licensee MO1222 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Diabetes Type II

Due to or as a consequence of: Sequentially list conditions, in any transfer underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed <u>Hypertension</u> physician a Box 68760 Physician/Medical Renal Disease as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death signed by the a d be detached for P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page certificate 1∏ Yes Division or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 📉 No 2 KER/Outpatient 3 DOA ٩ After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 🕅 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Registrar

29b. Signature and title of certifie.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Dr. John Molesworth D.O.

APR 0 9 2008

DHMH 17 Rev 1/2001

29c. License number

MDH40539

/ 400 W. 7th Street, Frederick, MD 21701

29d. Date signed (Month, Day, Year)

April 2, 2008

08-02554 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Allen Davenport State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Medical Examiner March 31, 2008 1700 hrs EDWARD 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harbor Hospital Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Hours Director 20.92.0986 1 M 2 F Country) Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits County Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? S.A Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Yes Specify: WhITE 4 Divorced Widowed Yes, Give Year Yes 2 No specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7: Department of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) umatic event, Be E. DAVENFORT (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) 20c. Location - City or Town, State 2 Cremation 3 crematory or other place) Removal from State tant: Other Specify Donation 5 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part I. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician een Onset and /Medical Death Compilcations of Hypertensive Cardiovascular Disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physician or use as the burial -UNPENDED AMENDED that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law s certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be of Vital Hospital: 1 Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 Other: this 1 ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Naturai Division Pending 1 Yes 2 No Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral

Medical

State Registrar

29b. Signature and title of certifier

David Fowler M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006** 

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 1, 2008

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

Chief Medical Examiner

32 Registrar's Signature

|                       |  |                | For State Registrar  | State  | of Maryla                                      |                                       | artment of I<br>rtificate of               |                                | and Me                     |   | jiene                       | 2008                           | 3                              | 564                     |
|-----------------------|--|----------------|--|--|--|---------------------------------------|--|--------------------------------|----------------------------|---|-----------------------------|--------------------------------|--------------------------------|-------------------------|
| ľ                     |  |                | Decedent's Name (First, Middle   | le, Last)  |  |                                       |  |                                | 2                          | 2. Date of Dea                              | th                          |                                | 3. Time                        | of Death                |
|                       | Physici<br>/Medic  |                | Revelyn  | К.   | Eisens   | stadt                                 |  |                                |                            | Month<br>March                              | 24, 2                       | .008                           | 5:45                           | P M                     |
| )-                    | Examir   |                | 4a. Facility Name (If not institution  | n, give street and n                               | umber)   |                                       | 4b. City, Town,                            | or Location of                 | f Death                    |   | 4c. Co                      | unty of Deat                   | h                              |                         |
|                       | 1000<br>1000<br>1000<br>1000<br>1000<br>1000<br>1000<br>100  |                | 5400 Vantage Po  |  |  | t                                     |  | olumbia                        | 04 Hrs. T.o.               |   |                             |                                | oward                          |                         |
| op.                   | Funeral<br>Director  |                | 5. Social Security Number 096-09-9005  | 6. Sex<br>1 ☐ M 2 X F                              |  | 91 Yrs.                               | Months Days                                |                                | Min.                       | B. Date of Birth<br>(Month, Day<br>ebruary  | , Year)                     | Co.                            | nplace (State<br>untry)<br>New | York                    |
|                       | and  |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c.   | City, Town or Le                      | ocation                                    |                                |                            |   |                             |                                | 10d. Inside                    | City Limits             |
|                       | Maryl<br>f sho   | ō              | Maryland   | Howard   |  |                                       | Co   | lumbia                         |                            |   |                             |                                |                                | s 2∐No                  |
|                       | r 28a  | Director       | 10e. Street and Number   | doward   |  |                                       | 10f. Zip Code                              | шола                           |                            | 1   | 0g. Citizen                 | of What Co                     | untry?                         |                         |
|                       | th wit   |                | 5400 Vantage Po  | oint Road.   | #1104  |                                       |  | 21044                          |                            |   |                             | U.S                            | .A.                            |                         |
|                       | ems<br>ems   | Funeral        | 11. Marital Status   |  | cedent Ever in                                 | n U.S. 13.                            | Was Decedent of I                          |                                | jin? (Speci<br>. Puerto Ri | ify Yes or No-                              | 14.                         | Race - Amer<br>Black, White    | rican Indian,                  |                         |
| 20                    | s afte   | by Fu          | 1 Never Married 2 Mar  | If Yes, C  | 2 ☑ No<br>give                                 |                                       | 1 ☐ Yes 2 🗷 No                             |                                |                            | . , ,                                       |                             |                                | Caucasia                       | an                      |
| Ş                     | hours<br>tural'<br>al Ex   | d be           | 3 X Widowed 4 Divorced   | Year or  | Dates:   | 16a Daca                              | dent's Usual Occu                          | nation                         |                            |   |                             | of Business/l                  |                                |                         |
| Ċ                     | in 72<br>n "na<br>ledic  | plete          | (Specify only highe  | st grade completed                                 | ·  | i (Give                               | kind of work done DO NOT use retire        | durina most                    | of working                 | 7   | TOD. KING                   | or business/i                  | industry                       |                         |
| 77                    | with<br>giene.<br>r thai   | Completed      | Elementary/Secondary (0-12) 12   | College  | (1-4or 5+)                                     |                                       | Statis                                     | tician                         |                            |   | Fee                         | deral G                        | overnmen                       | nt                      |
| ٥                     | e filed within 72 hours after death with the Maryland al Hygiene.  other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at   | BeC            | 17. Father's Name (First, Middle,  | Last)  |  |                                       |  | 18. Mother                     | r's Name (i                | First, Middle,                              | Maiden Sui                  | rname)                         |                                |                         |
| <u>a</u>              | ould b<br>Menta<br>arked   | 10             | Willian  | n J. Kamp  |  |                                       |  |                                | Ro                         | ose Bern                                    | stein                       |                                |                                |                         |
| a<br>I                | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at |                | 19a. Informant's Name/Relations  | ship (Type. Print)                                 |  | 19b. Maili                            | ng Address (Street                         | t and Numbe                    | r or Rural i               | Route Numbe                                 | r, City or To               | own, State, 2                  | (ip Code)                      |                         |
| a`<br>o`              | l and<br>Health<br>I'm 27<br>her tr  | 1              | Susan Dreifuss   | - Daughter   | 100  |                                       | Graniteknol                                |                                |                            |   |                             |                                |                                |                         |
| Š<br>O                | iges 1<br>nt of 1-<br>if ite<br>or ot  |                | 20a. Method of Disposition 1   Burial 2 □ Cremation  |  | n State  | cemetery, cre                         | osition (Name of<br>matory or other pla    | ice)                           | Dat                        | te  | 20c. Locati                 | ion - City or                  | Town, State                    |                         |
| Baitimore, Maryland 2 | iit. Pa<br>intmer<br>intant<br>njury   | 1              | 4 □ Donation 5 □ Other (S<br>21. Signature of Funeral Service  |  | J  |                                       | orial Garde                                |                                | 3/26/2                     |   |                             | , Maryla                       |                                | T.                      |
| g                     | permit. Pages 1 Department of H Important: If Ite any Injury or otl  | Ų,             | 150/6/6  | 7  |  |                                       | 2. Name and Address. 800 New               |                                |                            |   |                             |                                |                                |                         |
| Ŋ.                    |  |                | 23a. Part1. Enter the disease, o shock, or heart failure. List   | complications that                                 | caused the d                                   |                                       |  |                                |                            |   |                             | SPII                           | Approxim-<br>Interval B        | ate                     |
| 44                    | Physician  |                | Immediate Cause (Final disease or condition  |  |  |                                       | diovascula                                 |                                |                            |   |                             |                                | Onset and                      | d Death                 |
| j                     | /Medical   |                | resulting in death)  |  | o (or as a cons                                |                                       | urovascura                                 | Diseas                         | se                         |   |                             |                                |                                |                         |
|                       | Examiner   |                | Sequentially list conditions.  |  | rtic Ste                                       |                                       |  |                                |                            |   |                             |                                |                                | _                       |
| Ŷ                     | ed sit   | ine            | Sequentially list conditions, if any leading to invite data cause. Enter Underlying Cause (Disease or injury |  |  | sequence of)r                         |  |                                |                            |   |                             |                                |                                |                         |
|                       | xecut<br>and<br>II-tran  | Examiner       | that initiated events<br>resulting in death) Last  | U  | rial Fib                                       | rillation<br>sequence of):            |  |                                |                            |   |                             |                                |                                |                         |
| 8/60                  | certificate be executed rding physician and ise as the burial-transit  | dical E        |  |  | ,  | , ,                                   |  |                                |                            |   |                             |                                |                                |                         |
| ρ                     | ificate<br>g phys<br>as the  | edic           |  | 0  |  |                                       |  |                                |                            |   |                             |                                |                                |                         |
| ž                     | h cert<br>endin  | In/M           | IF FEMALE:<br>23b. Was decedent pregnant   |  | utcome pf pre                                  |                                       | ∃Ectopic pregnanc                          |                                |                            |   | 23d                         | . Date of deli                 | very                           |                         |
|                       | w requires that the death certific<br>been signed by the attending I<br>should be detached for use as  | Physician/Me   | in the past 12 months?<br>1 ☐ Yes 2 🗷 No   |  | gnant at time                                  |                                       | Other (specify)                            | , у                            |                            |   |                             | Month                          | Day                            | Year                    |
| r<br>Ö                | requires that the<br>een signed by th  | Phy            | 9 Unknown  |  |  |                                       |  |                                |                            | 00 5:11                                     |                             |                                |                                |                         |
| Š                     | ires the   | þ              | Part II. Other significant conditi   | ons contributing to                                | death but not                                  | resulting in the u                    | nderlying cause gi                         | ven in Part I.                 |                            |   | baccouse i<br>es 2.√.N      |                                | the cause of obably 4          |                         |
| ecord                 | requ   | eted           |  |  |  |                                       |  |                                |                            |   |                             |                                |                                |                         |
| ě                     | The faw<br>ite has b   | Completed      |  |  |  |                                       |  |                                |                            | 24a. Was a autops perfor                    | sy                          | 4b. Were au<br>prior to death? | topsy finding<br>completion of | s available<br>cause of |
| VITAI                 |  |                | 25. Was case referred to medica  |  |  |                                       |  |                                |                            | 1□ Yes                                      | 2K No                       | 1 ☐ Yes                        | 2 No                           |                         |
| >                     | Physician;<br>r this certific<br>ral director,   | o Be           | examiner?  1 Yes 2 No  | Hospital:  | Inpatient 2                                    | 2 ☐ ER/Outpatie                       | ot 3 DOA Ot                                | C-14.5.1.                      |                            | <i>Check only or</i><br>e 5 <b>⊠</b> Reside |                             | Other (Con                     | :4.)                           | Targette and            |
| ō                     | nding Phys<br>h.<br>: After this<br>funeral di   | n: To          | 27. Manner of Death  | 28a. Dat   | e of Injury<br>onth, Day Year                  | 28b. Time o                           | f 28c. Inju                                | ry at                          | 28                         | d. Describe h                               | ow injury or                | ccurred                        | illy)                          | •                       |
| sion                  | ath.<br>or: Aft  | atio           | 1 Natural 5 Pendir investi   | gation   | iiii, Day rea                                  | r) Injury                             |  | Yes 2□N                        | No                         |   |                             |                                |                                |                         |
| <u> </u>              | al or Attending F<br>s after death.<br>I Director: After<br>d in by the funer  | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ   | ained 286. Plac                                    | ce of injury - A                               |                                       | eet, factory, office                       |                                | 28                         | f. Location (S. City or Town                | treet and N<br>n, State)    | umber or Ru                    | ral Route Nu                   | mber,                   |
|                       | urs af   |                |  |  |  |                                       |  |                                |                            |   |                             |                                |                                |                         |
|                       | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | edical         | 29a. Certifier 1   (Check only one)   1   Certifyii   2   Medical  | ng Physician: To the<br>Examiner: On the<br>and ma | ne best of my<br>basis of exan<br>nner stated. | knowledge, deat<br>nination and/or ir | n occurred at the to<br>vestigation, in my | ime, date and<br>opinion, deat | d place, an<br>th occurred | nd due to the o<br>d at the time, o         | ause(s) and<br>late and pla | d manner as<br>ace, and due    | stated.<br>to the cause        | e(s)                    |
|                       | o the  | Mec            | 29b. Signature and title of certifie   |  | anor stateu.                                   |                                       | 29c. Licen:                                | se number                      |                            | 2   | 9d. Date si                 | igned (Monti                   | n, Day, Year)                  |                         |
|                       | 17/  |                | > 5  | Aune   |  |                                       | I  | 030641                         |                            |   | Mar                         | ch 25,                         | 2008                           |                         |
|                       | 10   |                | 30. Name and address of person   |  |  | Item 23a) (Type,                      |  |                                |                            |   | riai                        | C11 4J;                        | 2000                           |                         |
| _                     |  |                | Ramesh Sabapsthi   |  |  |                                       | Neck Road,                                 | Baltimo                        | ore, Ma                    | aryland :                                   | 21221                       |                                |                                |                         |
|                       | Sta  |                | 31. Date filed (Month, Day, Year)  |  | egistrar's Si                                  |                                       | ant a                                      |                                |                            |   |                             |                                |                                |                         |
| DL                    | Registr  |                | MAR 2 6  | 2000   |  | J. Ag                                 |  |                                |                            |   |                             |                                |                                |                         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 14 Arvonzey Elam 2008 /Medical March 3:45pm 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hospital Prince George's Ft. Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. II, 1955 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 □ M 2 💢 F 53 577-74-5052 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f sho 1√ Yes 2 No Directo Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important; if item 27 is marked other than "..." 6336 Bentham Dr. by Funeral 20744 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Admin. Asst. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney Elam Carrie Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chereka V. Elam/Daughter 6336 Bentham Dr., Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. Mar.22,2008 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ft. Lincoln F. H. 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications the valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) O(ard **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2⊠ No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 2 K ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Vithin 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State MAR 2 1 2008 Registrar

1221 Mercentile Ln., Largo, MD 20774 Ronald Wheeler, M.D. 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| Pedro Camilo Mar   | tine      | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg   |   |
|--|-----------|--|---|
|  |           | 1-For State Registrar Ameno#20c. PerFHPQC4_4_08cr Certificate of Death Reg   | 3. No. 2008 155                                       |
| Physician<br>Medical Examine   | "         | 1. Decedent's Name (First, Middle,Last)  2. Date of Death  | Day Year occor  |
| 7"   |           | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   | 4c. County of Death                                   |
|  |           | 33 Jefferson Place Annapolis   | Anne Arundel  |
| Funeral  |           |  | (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) |
| Director   | 1         |  | 9, 1971 Mexico  |
| *  | -         | Usual Residence of Decedent  | Land Leite Ohn Limite                                 |
| w any  |           | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits  1 X Yes 2 No                 |
| yland<br>-f she  | 힐.        | MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10  |   |
| or 28s   | <u> </u>  | 2  | g. Citizen of What Country?                           |
| ith th   | 計         | 33 Jefferson Place 21401 Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-   | 14. Race - American Indian, Black,                    |
| eath y   | 9         | 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  | White, etc.   |
| iffer d  | 5         | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify: Mexican  | Specify: White  |
| lours a  | g<br>D    |  | 16b. Kind of Business/Industry                        |
| n 72 h   | i je      | Elementary/Secondary (0-12) College (1-4 or 5+)  |   |
| withing siene.   | Ē -       | 15. Decedent's Education (Specify only highest grade completed)    16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   12th  | Restaurant  |
| 21215-0036 Uld be filed within 7 Mental Hygiene c event, the Medica  |           | Juan Martinez  Susana Enriquez   |   |
| 212<br>212<br>Ment bound | 라         | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numb |   |
| MD<br>12 shc<br>th and<br>127 is<br>umati  |           | Jose E. Martinez (Brother) 603 Truxton Rd. Annapolis Mar   | yland 21409   |
| Te, land Heal  | T         | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)  | 20c. Location - City or Town, State                   |
| Pages<br>Perit of  |           | Centation 5 Kentoval Itom State  | Puebla, Mexico  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.   | 1         | 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility IJ H Racon  |   |
|  | 1         | Windh C. Bacon CC 36/ 3447 14th St. N.W. Washing   | ton DC 20010.   |
| Physician<br>/Medical  |           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrefailure. List only one cause on each line.  | Between Onset and                                     |
| xaminer  | ĺ         | Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease  Due to (or as a consequence of):   | Death   |
| T. No.   | 1         | Sequentially list conditions, b.   |   |
|  | 힐         | if any, leading to immediate Due to (or as a consequence of):  |   |
| _  | ۊ         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |   |
|  |           | ga.  |   |
|  | ğ         | XAMENDED XAMEND XAMENDED XAMEND XAMENDED XAMENDED XAMENDED XAMENDED XAMENDED XAMENDED XAMEND  |   |
| Box 68760, e death certificate be the attending physici ed for use as the buri   | <u></u> } | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  15 Female: 23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy   | 23d. Date of delivery  Month Day Year                 |
| ox 6   | 200       | y Pregnant at time of death 5 Other (Specify)  | 4   |
| the de   | 칅         | É GINIOWII   | bacco use contribute to the cause of death?           |
| P. C   | ≥         | ↑ Yes  |   |
| ds,  | 흵         | 24a. Was a autops perform 1 🗸 Yes 2  |   |
| e law<br>e has<br>ge 2 st  | 副         | autops<br>perfor   | med? death?   |
| n: The   |           |  | 2 No 1 Yes 2 No                                       |
| Vita<br>ysicia<br>this ce<br>direct  |           | m examiner?  | Residence 6 🗸 Other: Scene                            |
| of ng Ph   |           | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe h   | now injury occurred                                   |
| ion<br>ttendi<br>leath.<br>tor:  | 읉         | 1 Y Natural 5 Pending 1 Yes 2 No   |   |
| lor A<br>after a<br>Direct   | <b>≌</b>  | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (S or Town, Si   | treet and Number or Rural Route Number, City tate)    |
| Divis Hospital or A Funeral Dire stely filled in b   |           |  |   |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.  | lg        | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the  | 1.  |
| To with  | ĕ         | and manner stated.  29b. Signature and title of certifier  29c. License number   | 29d. Date signed (Month, Day, Year)                   |
|  |           | (interlegens) O.C.M.E.   | April 1, 2008   |
| 0 60   | +         | 30 Name and address of person who completed cause of death (Item 23a)  |   |
| K U  |           | Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |   |
| Stat   |           |  |   |
| Registra   | aľ        | CH APR V 4 2000 PROPERTY APPROPRIES  |   |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day March 29, 2008 Physician 1:30 Aloysius Francis Fenwick IV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**™**M 2□F 68 215-36-2787 Yrs June 11, 1939 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Director St. Mary's Helen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39305 St. Thomas Drive 20635 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: <u>ک</u> 3 Widowed 4 Divorced Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Computer Programer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aloysius Francis Fenwick III Anabel Barto ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39305 St. Thomas Drive Helen, MD permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Clara Agnes Fenwick / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State April 1. Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2008 21. Quature of Funeral Service Joseph 20. 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Ence Phalo Pata Immediate Cause (Final etubolic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HyPerculcemia that the death certificate be executed sician and burial-trans Due to (or as a consequence of physician the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>^</u> CAO, SIR Renal Trasplant 1 Tyes 2 No 3 Probably 4 Jonknown Completed Anemis HyperPunathynaid 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ulcer Decubitus Vital certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Division or 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Daje signed (Month, Day, Year)

00

Alonsing.

State Registrar 22650 Cedar Lane Court
32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Patel, M.D.

MAR 3 1

31. Date filed (Month, Day, Year)

Leonardtown, MD 20650

00062213

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                            | 1 - For State Registrar   |  | of Marylar  |                                 | artmei                           | nt of H                                 |                            | and M             | ental Hy                             | giene                | 2005                              | Antonio sp. o                         | 568                   |
|---------------------|--|----------------------------|---|--|---|---------------------------------|----------------------------------|---|----------------------------|-------------------|--------------------------------------|----------------------|-----------------------------------|---------------------------------------|-----------------------|
|                     |  |                            | Hegistrar     Decedent's Name (First, Middle, La  | st)  |   |                                 | illica                           | ie oi i                                 | Jeani                      |                   | 2. Date of De                        | Reg. No              |                                   | 3. Time o                             | f Death               |
|                     | Physici  | an                         | Rita Elizabeth Gr   |  |   |                                 |                                  |   |                            | 1                 | Month<br>March                       | Day                  |                                   |                                       | 5 P M                 |
|                     | /Medi  |                            | 4a. Facility Name (If not institution, given  | e street and nu                              | ım.ber)   |                                 | 4b City                          | Town or                                 | Location of                |                   | March                                |                      | County of Death                   | 3:4.                                  | ) E                   |
|                     | Examir   | ier                        | Homewood Nursing  |  |   | nd                              |                                  | deric                                   |                            |                   |                                      |                      | rederick                          |                                       |                       |
|                     | Funeral  |                            |   | Sex C  | 7. Age (In yrs.   |                                 | If Unde                          | r 1 Year                                | If Under                   | 24 Hrs.           | 8. Date of Bir                       | th.                  | O Riethe                          | place (State                          | or Foreign            |
|                     | Director   |                            | 410-28-3010 Usual Residence of Decedent   | 1□M 2⊠F                                      |   | 88 Yrs.                         | Months                           | Days                                    | Hours                      | Min.              | (Month, Da                           | 191                  | 9 Wash:                           | ington                                | D.C                   |
|                     | Maryland   | tor                        | 10a. State 10b. County  Maryland Frederic   | k  | 1   | ity, Town or Lo                 | ocation                          |   |                            |                   |                                      |                      |                                   | l0d. Inside C                         | City Limits<br>2 X No |
|                     | 28a  | rec                        | 10e. Street and Number  |  |   |                                 | 10f. Z                           | ip Code                                 |                            |                   |                                      | 10g. Cit             | izen of What Cou                  | ntry?                                 |                       |
|                     | 3a or  | 0                          | 3624 Byron Circle   |  |   |                                 |                                  | 21704                                   | ı                          |                   |                                      | Uni                  | ted Stat                          | es                                    |                       |
|                     | death ms 2   | Funeral Director           | 11. Marital Status  | 12. Was Dec                                  | edent Ever in U   | J.S. 13.                        |                                  |   |                            | igin? (Spe        | city Yes or No<br>Rican, etc.)       |                      | 14. Race - Americ                 | can Indian,                           |                       |
| 920                 | 72 hours after death with the Maryland<br>"naturel", or flems 23a or 28a-f ehow<br>idical Examiner must be notified at   |                            | 1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced  | Armed F<br>1 ☐ Yes<br>If Yes, G<br>Year or [ | 2 🛣 No<br>ive   |                                 |                                  |   | Specify:                   |                   | Hican, etc.)                         |                      | Black, White, Specify: Wh         | etc.                                  |                       |
| 215-0               |  | Completed by               | 15. Decedent's E<br>(Specify only highest gi  | ade completed,                               | 1-4or 5+)   | 16a. Dece<br>(Give              | dent's Us<br>kind of w<br>DO NOT | ual Occupa<br>ork done d<br>use retired | ation<br>during mos        | t of workii       | ng                                   | 16b. K               | ind of Business/In                | dustry                                |                       |
| 212                 | d with   | mo;                        | - Clothornary/cocorroary (6 12)   | 5+   |   | Regi                            | ster                             | ed Nu                                   | ırse                       |                   |                                      | M                    | edicine                           |                                       |                       |
| and                 | 2 should be filed withir<br>and Mental Hygiene.<br>ie marked other then<br>eumatic event, I.e.M.   | To Be C                    | 17. Father's Name (First, Middle, Las<br>Bernard Kummer   | ")   |   |                                 |                                  |   |                            | er's Name<br>dred | (First, Middle<br>Summ               |                      | Sumame)                           |                                       |                       |
| Maryland 21215-0036 | nit. Pages 1 and 2 should be filed within ortainent of Health and Mental Hygiene. ortant: if item 27 is marked other then injury or other treumatic event, the Mare 18.  | -                          | 19a. Informant's Name/Relationship John S. Grabowski  |  | Son)  |                                 |                                  |   |                            |                   | Route Numb                           |                      | or Town, State, Zij<br>704        | Code)                                 |                       |
| Baltimore,          | of Health<br>item 27<br>other tr   | 1                          | 20a. Method of Disposition  |  |   | Place of Dispo                  | osition (Na                      | ame of                                  | al la                      | March             | ate 2 /                              | 20c. L               | ocation - City or T               | own, State                            |                       |
| Ę                   | Pages<br>ent of<br>nt: ff li<br>ry or c  |                            | 1 ☐ Burial 2 ☑ Cremation 3 [<br>4 ☐ Donation 5 ☐ Other (Special   |  | State M   | etropo<br>Crema                 | litar                            | l                                       | · T                        | 2008<br>2008      | -                                    | ۸1۵                  | xandria.                          | Vire                                  | inta                  |
| alti.               | Department compositions of the properties of the |                            | 21. Signature of Funeral Service Lice   | 7  |   |                                 |                                  |   | ss of Facili               |                   |                                      |                      | 1 Home,                           | VIII                                  | IIIIa                 |
| ñ                   | Depa<br>impo<br>any i  |                            | M/m/  | The  |   | 116                             |                                  |   |                            |                   |                                      |                      | rsburg,                           | MD 20                                 | 877                   |
|                     | Physician<br>/Medical<br>Examiner  |                            | 23a. Part1. Enter the disease, or conthock for night tay ure. List only Immediate Cau a (Final disease or condition resulting in death) | _ a  | caused the de<br>each line.                               | Th                              | ter the mo                       | ode of dyin                             | g, such as                 | cardiaco          | r respiratory                        | errest,              | Disage                            | Approxima<br>Interval Be<br>Onset and | etween                |
|                     | cuted id   | Examiner                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events       | Due to                                       | OI da a conse   | quence of.                      |                                  |   |                            |                   |                                      |                      |                                   |                                       |                       |
| ,092                | te be executed<br>ysician and<br>ie burial-transit   | cal Exa                    | resulting in death) Last  | Due to                                       | (or as a conse  | quence of):                     |                                  |   |                            |                   |                                      |                      |                                   |                                       |                       |
| 89                  | certificate<br>nding phy<br>use as the   | -                          |   |  |   |                                 |                                  |   |                            |                   |                                      |                      | 1                                 |                                       |                       |
| .O. Box             | death<br>e atte  | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1□Live                                       | utcome of pregr<br>birth 2 Fet<br>mant at time of<br>nown | al death 3                      | ⊒Ectopic<br>⊒Other (s            | pregnancy<br>specify)                   |                            |                   |                                      |                      | 23d. Date of deliv<br>Month       | ery<br>Day                            | Year                  |
| <u>α</u>            | w requires that the<br>been signed by th<br>should be detache  | by Pt                      | Part II. Other significant conditions   | contributing to                              | death but not re  | sulting in the I                | ınderlying                       | cause giv                               | en in Part i               | 1.                |                                      | tobacco<br>Yes 2     | use contribute to                 | the cause of                          |                       |
| Ö                   | requ<br>been<br>shoul  | etec                       | 110/1   |  |   |                                 |                                  |   |                            |                   |                                      |                      |                                   |                                       |                       |
| Vital Records,      | The la<br>ate has<br>page 2  | Comp                       | Dhen.   | mo.  | 211   |                                 |                                  |   |                            |                   | 24a. Was<br>auto<br>perfe<br>1 ☐ Yes |                      | death?                            | ompletion of                          | cause of              |
| /ita                | ysician: Th<br>is certificate<br>director, pag   | Be                         | 25. Was case refer ed to medical examine?   |  |   |                                 |                                  |   |                            | e of Death        | (Check only                          | one)                 |                                   |                                       |                       |
| of \                | Physician:<br>this certific<br>ral director,   | ဥ                          | 1 Yes 22 No   |  |   | ER/Outpatie                     | nt 3 🗆 🛭                         |   | A DAVI                     | ursing Hor        | me 5□Res                             | idence               | 6 ☐Other (Speci                   | fy)                                   |                       |
| ion                 | Iling<br>After<br>fune   | ation:                     | 27. Manner Death  2 Accident investigate  | on   | of Injury<br>nth, Day Year)                               | 28b. Time of<br>Injury          | of<br>M                          | 28c. Injun<br>Worl                      |                            |                   | 28d. Describe                        | how inju             | ry occurred                       |                                       |                       |
| Division            | ai or Atte<br>s after de<br>si Directo   | Certification:             | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined   | 200. Plac                                    | e of Injury - At I<br>ding, etc. (Spec                    | nome, farm, st<br>ify)          | reet, facto                      | ry, office                              |                            |                   | 28f. Location (<br>City or To        | (Street a            | nd Number or Rur<br>a)            | al Route Nu                           | mber,                 |
|                     | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  | Medical (                  | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa  | miner: On the                                | e best of my kn<br>basis of examin<br>prier stated.       | owledge, dea<br>ation and/or in | th occurre<br>rvestigation       | d at the tin                            | ne, date ar<br>pinion, dea | nd place, a       | and due to the<br>ed at the time,    | cause(s<br>, date an | and manner as<br>d place, and due | stated.<br>to the cause               | (s)                   |
|                     | To the within To the Comp  | Σ                          | 29b. Signature and title of certifier   |  | 1/ -  |                                 | 2                                | 9c. Licens                              | e number                   | ^                 |                                      | 29d. Da              | ite signed (Month,                | Day, Year)                            | -/                    |
|                     | 3  |                            | 1 Asp   | n(   | 1_  |                                 | 20                               | Di                                      | 642                        | 28                |                                      |                      | 5/20                              | 108                                   | 5                     |
|                     |  |                            | 30. Name and address of person who  |  | W. 9th  |                                 |                                  | adard                                   | ick 1                      | MTD 21            | 701                                  |                      |                                   | ,                                     |                       |
|                     | St   | ate                        | Casper Cline, M.I 31. Date filed (Month, Day, Year)   |  | Registrar's Sign  |                                 | F L                              | cucii                                   | LURY                       | <u>πν Ζ1</u>      | ,,01                                 |                      |                                   |                                       |                       |
|                     | Regist   |                            |   | 008  | Buch  | 15 A                            | BALL                             | 7                                       |                            |                   |                                      |                      |                                   |                                       |                       |

Kirby Hirolowych

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. **Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

23a or

or items,

"natural",

I Hygiene.

the Medical

Examiner must be notified at

Director

Funeral

þ

Completed

Be

MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine attending physician Physician/Medical Completed Be Certification: To After t after death To the Hospital within 24 hours a To the Funeral C Medical

disease 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DO43 83

March 26, 2008

Bay View Circle

21224

7+1 State

Grec 31. Date filed (Month, Day, Year) MAR 2 7 2008

Baltimore, FD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopking

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 7:10 p M 24 2008 Arthetta Jane Gorden March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 126 College View Blvd Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Director 08 1932 PA 168-28-0311 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? natural", or items 23a or the Medical Examiner must be 126 College View Blvd 21157 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 **Homemaker** Own Home permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important; If item 27 is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur M. Wolford Mabel E. Ankney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 College View Blvd Westminster, MD Dale Gorden/Husband 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 03/2772008 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Westmoreland Co. Memorial Pk Greensburg, PA 21. Signature of Funeral Service Licens Printed Romeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 years disease or condition resulting in death) Muscular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Linknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autops, performed: certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Funeral Director: After To the Hospital or Attending within 24 hours after death. 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) MAR 2 6

29b. Signature and title of certifier

rimberly A

ohnstan 32. Registrar's Signature

2008

cause of death (Item 23a) (Type, Print)

444 WMC Drive Westminster, MD 21158

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gillis George Howard MARCI £3 2008 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 5AL1564164 NICOMICO If Under 1 Year If Under 24 Hrs 5. Social Security Number . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Min. Hours 1X M 2 ☐ F 62 218-48-8455 Director 11/3/1945 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Wicomico Salisbury 1 XYes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 Winder St. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: white Specify: 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) disabled n/a is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Marguerite Jackson Marion H. Gillis Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Betty G. Hidalgo/sister 5574 Ginger Tree Lane, Toledo, OH 43611 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State Injury or 3/26/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park Storiature of Funeral Service License <sup>22</sup> Name and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Enter the disease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cau a on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic Carama know /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1□ Yes 1 TYes 2 🗆 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical

Division or Vital Records, P.O. Box 68760, An 24 hour.

The Funeral Directory filled in by To

5548-84-810

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year)

31. Date filed (Month, Day, Year)

3085

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Church G. S. V. a Tr MD Pen

Kegianal Medical

State Registrar

MAR 2 6 2008



|            |   |                | For<br>State<br>Registrar   | State of Ma  |                                     | epartmei<br>Certifica                  |                              |  | ind Me                     | -                            | •                              | 2008  | 11572  |
|------------|---|----------------|---|--|-------------------------------------|--|------------------------------|--|----------------------------|------------------------------|--------------------------------|---|--|
| F          |   | 9              | negistrar     Decedent's Name (First, Middle, Last                          |  |                                     | ortinoa                                |                              | - Cutii                                | 2                          | 2. Date of De                | Reg. No                        | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,       | 3. Time of Death                                   |
|            | Physici<br>/Medic   |                | ELOIS HAMILTON  |  |                                     |  |                              |  |                            | Month<br>MARCH               | 19.                            |   | 8:22 A M   |
|            | Examin  |                | 4a. Facility Name (If not institution, give                                 | street and number)   |                                     | 4b. City                               | , Town, or                   | Location of                            |                            |                              |                                | . County of Deat                              |  |
|            |   | 20             | 5115 TEMPLE HILLS   |  |                                     |  | PLE H                        |  |                            |                              |                                | INCE GE                                       | ORGES  |
| И          | Funeral   |                | 5. Social Security Number 6. S  | ex 7.Age<br>□M 2 <b>K</b> iF   | e (In yrs. last birtho<br>Yr        | Months                                 | Days                         | If Under 2<br>Hours                    | Min.                       | B. Date of Bir<br>(Month, Da | ay, Year,                      | Co  | hplace (State or Foreign<br>ountry)                |
| 3,4        | Director  |                | 098-30-2373   |  | 70 YF                               |  |                              |  | 1                          | .2/08/                       | 1937                           | NOR'  | TH CAROLINA  |
|            | yland<br>yland<br>at  |                | 10a. State 10b. County  |  | 10c. City, Town o                   |  |                              |  |                            |                              |                                |   | 10d. Inside City Limits                            |
|            | e Mar<br>a-f sl   | ctor           | MD PRINCE GI  | EORGES   | TEMPLE I                            | HILLS                                  |                              |  |                            |                              |                                |   | 1 X Yes 2 No                                       |
|            | ith th<br>or 28   | Director       | 10e. Street and Number  |  |                                     |  | p Code                       |  |                            |                              | 10g. Ci                        | tizen of What Co                              | ountry?  |
|            | s 23a   |                | 5115 TEMPLE HILLS   |  |                                     | 207                                    |                              |  | 1-0 (0                     |                              | US                             |   | don Indian   |
| 36         | be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced | 12. Was Decedent B<br>Armed Forces?<br>1 ☐ Yes <b>2\\</b> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | ver in U.S.                         | 13. Was Dece<br>If Yes, spe<br>1 ☐ Yes |                              | spanic Orig<br>n, Mexican,<br>Specify: | jin? (Speci<br>, Puerto Ri | ity Yes or No<br>ican, etc.) | )-                             | 14. Race - Ame<br>Black, White<br>Specify: BL | e, etc.  |
| 21215-0036 | 2 hou   | ted            | 15. Decedent's Ed   | ucation  | 16a. D                              | ecedent's Usi                          | ual Occupa                   | ition                                  | -6                         |                              | 16b. K                         | (ind of Business/                             | Industry   |
| 215        | thin 7<br>le.<br>lan "r<br>Med  | Completed      | (Specify only highest gra   | College (1-4or 5   | +) (6                               | Give kind of w<br>fe. DO NOT (         | ork done d<br>use retired)   | uring most<br>)                        | or working                 | 7                            |                                |   |  |
| 2          | lygien<br>lygien<br>her th  | Co             | 12TH  |  | NUE                                 | RSE                                    | -                            |  |                            |                              |                                | VATE  |  |
| Maryland   | be<br>d o   | Be             | 17. Father's Name (First, Middle, Last) GURNIE GRIFFIN                      |  |                                     |  |                              |  |                            | First, Middle,<br>BERTS      | , Maider                       | Surname)                                      |  |
| <u> </u>   | should by Menta marked  | မ              | 19a. Informant's Name/Relationship  | Type Print)  | 19b M                               | lailing Addres                         | s (Street a                  |  |                            |                              | er City                        | or Town, State, 2                             | Zin Code)  |
|            | s 1 and 2 should<br>if Health and Mer<br>Item 27 Is marke<br>other traumatic  |                | BIANCA FLOYD/DAUG   |  |                                     |  |                              |  |                            |                              | -                              |   | •  |
| Ē,         | of Hea  | - 9            | 20a. Method of Disposition  |  | 20b. Place of D                     | isposition (Na<br>crematory or         | ime of                       |  | Da                         | te                           | 20c. L                         | LLS, MD ocation - City or                     | Town, State  |
| Ē          |   |                | 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                 |  | CEDAR H                             | -                                      |                              |  | 3/26                       | /2008                        | SUIT                           | LAND, M                                       | D  |
| Baltimore, | permit. Pag<br>Department<br>Important: I<br>any Injury o   |                | 21. Signature of Funeral Service Licer                                      | see /  | ,                                   |  |                              |  |                            |                              |                                | FUNERAL                                       | HOME   |
|            | 90 E 8 9  |                | Mul   | UCCUCA   |                                     |  |                              |  |                            |                              |                                | D 20785                                       |  |
|            |   |                | 23a. Part1. Enter the disea e, or comshock, or heart failure. List only     |  |                                     |  | de of dying                  | g, such as o                           | cardiac or                 | respiratory a                | rrest,                         |   | Approximate<br>Interval Between<br>Onset and Death |
|            | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)             | a  | TIC CANC                            |  |                              |  |                            |                              |                                |   |  |
|            | Examiner  |                |   | Due to (or as a  | a consequence of)                   |  |                              |  |                            |                              |                                |   |  |
| S          | 46 4  | Jer            | Sequentially list conditions, if any, leading to immediate                  | b. Due to (or as a   | a consequence of)                   |  |                              |  |                            |                              |                                |   |  |
|            | cuted<br>nd<br>ransit   | Examiner       | that initiated events   | C.   |                                     |  |                              |  |                            |                              |                                |   |  |
| Ď,         | be executed<br>sician and<br>burial-transit   |                | resulting in death) Last  | Due to (or as a  | a consequence of)                   |  |                              |  |                            |                              |                                |   |  |
| 8760,      | ate<br>the  | dical          |   | d  |                                     |  |                              |  |                            |                              |                                |   |  |
| Š<br>S     | leath certific<br>attending p<br>for use as   | /Me            | IF FEMALE:  | 23c. If yes, outcome   | nf nregnancy                        |  |                              |  |                            |                              |                                |   | - 17, 5-20, 5000.                                  |
| Ř          | the death certifi<br>y the attending<br>ched for use as   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                           | 1 ☐ Live birth<br>4 ☐ Pregnant at  | 2 Fetal death                       | 3 ☐ Ectopic p                          |                              |  |                            |                              |                                | 23d. Date of del<br>Month                     | livery<br>Day Year                                 |
| j.         | y the   | ysi            | 1 ☐ Yes 2 🔁 No<br>9 ☐ Unknown   | 9□Unknown  | o or dodain                         | 0                                      | poony/                       |  |                            |                              |                                |   |  |
| Ω,<br>J    | The law requires that the de te has been signed by the a lage 2 should be detached  | by P           | Part II. Other significant conditions of                                    | ontributing to death bu  | it not resulting in th              | e underlying                           | cause give                   | n in Part I.                           |                            |                              |                                |   | the cause of death?                                |
| Hecords,   | equire<br>en siç<br>ould b  | edk            |   |  |                                     |  |                              |  |                            | XX                           | Yes 2                          | □ No 3□ Pr                                    | robably 4 □Unknown                                 |
| ပ္ပ        |   | Completed      |   |  |                                     |  |                              |  |                            | 24a. Was                     | an<br>psv                      | 24b. Were au                                  | utopsy findings available completion of cause of   |
|            | 40 67   | Con            |   |  |                                     |  |                              |  |                            | perfo                        | psy<br>ormed?<br>2 <b>X</b> No | death?<br>1 ☐ Yes                             | **   |
| VItal      | Physiclan: The la<br>this certificate has<br>ral director, page 2   | Be             | 25. Was case referred to medical examiner?                                  | Hospital:  |                                     |  | Otho                         |  |                            | Check only o                 |                                |   |  |
| Ö          | Phy<br>this<br>al di  | 2              | 1 ☐ Yes 2X No<br>27. Manner of Death  | 1 ☐ Inpatie  |                                     |  |                              | 4 🗆 Mui                                |                            | e 5X Resi                    |                                | 6 □Other (Spe                                 | cify)  |
| 0          | Attending I<br>r death.<br>ector: After<br>by the funer   | tion           | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigation                       | (Month, Day  | Year) Inju                          | ry M                                   | 28c. Injury<br>Work<br>1 ☐ Y | ?ົ<br>′es 2 ∐ N                        | - 1                        | d. Describe                  | now inju                       | ry occurred                                   |  |
| UNISION    | or Attendater death   | ifica          | 3 Suicide 6 Could not be<br>4 Homicide determined                           | 28e. Place of inju   | ry - At home, farm                  | , street, factor                       | ry, office                   |  | 28                         | f. Location (                | Street a                       | nd Number or Ru                               | ural Route Number,                                 |
| 5          | tal or A<br>s after<br>al Dire<br>ed in b   | Certification: | 4   Hormolde  | building, etc  | . (Specify)                         |  |                              |  |                            | City or To                   | wn, Stati                      | ₽)  |  |
|            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   |                | Check only 2 Medical Exam   | ysician: To the best of<br>niner: On the basis of  | of my knowledge, dexamination and/o | eath occurred                          | at the tim                   | e, date and                            | d place, an                | d due to the                 | cause(s                        | and manner as                                 | s stated.  |
|            | To the I within 2.  | Medical        | 29b. Signature and title of certifies                                       | and manner sta   | ted.                                |  | c. License                   |  |                            |                              |                                |   |  |
|            | with Co   |                | 200. Oignature and the of certifie  |  |                                     | 1                                      | D7702                        |  |                            |                              |                                | ite signed <i>(Mont</i><br>CH 20, 2           |  |
| ,/         | ,   | ŀ              | 30. Name and address of person who  | completed cause of de  | eath (Item 23a) (Tu                 | ne Print\                              |                              |  |                            |                              |                                |   |  |
| 1          |   |                | LUIS DIAZ 401 NO  |  |                                     |  | MD 21                        | 231                                    |                            |                              |                                |   |  |
|            | Sta   |                | 31. Date filed (Month, Day, Year) MAR 2 1 2008                              | 32. Registra   | ar's Signature                      |  |                              |  |                            |                              |                                |   |  |
|            | Registr   | ar             | MWW & T CORD  | MAN.   | H April                             | 2                                      |                              |  |                            |                              |                                |   |  |

|   |                | 1 - For Amend Items Registrar  | State of Ma<br>1,25 per                              | ryland / Den<br>me, g879, 0                   | artment of He<br>5/13/08dhi<br>rtificate of L | ealth and<br><i>eath</i>            |   | ene 2 (            | 108 11573  |
|---|----------------|--|--|---|---|-------------------------------------|---|--------------------|--|
| Physici   |                | Decedent's Name (First, Middle, Last,  | )  |   |   |                                     | Date of Death     Month                         | Day                | 3. Time of Death   |
| Physici<br>/Medic   |                | Helene, s.   | , Her  | shey  |   |                                     | March   |                    | 2008 10:36 AM  |
| Examin  | er             | 4a. Facility Name (If not institution, give  | street and number)                                   | /   | 4b. City, Town, or I                          | Location of Dea                     | ath   | 4c. County         | of Death   |
|   |                | University of Mary   |  |   | Baltimo                                       |                                     |   | nja                |  |
| Funeral   | ) i            | 5. Social Security Number 6. Se  | 7. Age   | (In yrs. last birthday)                       | If Under 1 Year Months Days                   | If Under 24 Hr<br>Hours Mir         |   | Year)              | Birthplace (State or Foreign Country)                              |
| Director  |                | 119-16-3949  | J IVI 2 (4) F  | 81 Yrs.                                       |   |                                     | Nov. 25   |                    | New York   |
| pug "   |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or Lo                         | ocation                                       |                                     |   |                    | 10d. Inside City Limits  |
| laryla<br>shor  | 5              |  |  |   |   |                                     |   |                    | 1 □ Yes 2X No  |
| he M<br>28a-f<br>otifik   | Director       | DE Sussex  |  | Frankf  |   |                                     | 140   | 031                |  |
| with t  | ä              | 10e. Street and Number   |  |   | 10f. Zip Code                                 |                                     | 10  | g. Citizen of      | What Country?  |
| death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at  | Funeral        | 25 Clamshell Lan   |  |   |   | 945                                 |   | USA                | A  |
| er de<br>Item<br>ner n  | Š              | 11. Marital Status   | 12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☐ No. | ver in U.S.                                   | Was Decedent of His<br>If Yes, specify Cubar  | spanic Ongin? (<br>n, Mexican, Pue  | Specify Yes of No-<br>erto Rican, etc.)         |                    | ce - American Indian,<br>ck, White, etc.                           |
| s aff   | by F           | 1 Never Married 2 Married 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                       | °   | 1□Yes 🏝 No                                    | Specify:                            |   | Specif             | y: <b>White</b>  |
| 3-UUSO 72 hours af natural", or   |                | 15. Decedent's Edu   |  | 16a Dece                                      | dent's Usual Occupa                           | tion                                | 11  | 6b Kind of B       | usiness/Industry   |
| in 72<br>in 72<br>in a  | Completed      | (Specify only highest grad   | le completed)  | (Give   | kind of work done du<br>DO NOT use retired)   | uring most of w                     | orking  | ob. Italia of C    | doiness/modelly  |
| withi<br>ene.<br>than   | E C            | Elementary/Secondary (0-12)  | College (1-4or 5+                                    | -)  | ecial Age                                     |                                     | E   | Feder              | ral Government   |
| ING Z IZ 13-UU30  be filed within 72 hours after death with the Marylar at Hygiene.  and Hygiene.  ad other than "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at   |                | 17. Father's Name (First, Middle, Last)  |  |   |   |                                     | ame (First, Middle, M                           |                    |  |
| d be filk<br>antal Hy<br>ced oth  | o Be           | Emanuel Abrams   |  |   |   | Hen                                 | rietta (Pa                                      | anr)               | •  |
| aryland 2 should be filed v and Mental Hygie s marked other t umatic event, tb  | ည              | 19a. Informant's Name/Relationship (Ty   | rpe. Print)  | 19b. Mailii                                   | ng Address (Street a                          |                                     | Rural Route Number,                             | · ·                | State Zin Code)  |
| Man<br>d 2 s<br>lth an<br>27 is r<br>traur  |                | Marian Merewitz  | ,  | 1   |   |                                     | ookeville,                                      | -                  |  |
| Hear<br>Hear<br>tem 2   | 1 0            | 20a. Method of Disposition   | buugireei  | 20b. Place of Dispo                           | osition (Name of                              |                                     |   |                    | - City or Town, State  |
| ages<br>nt of<br>t: If it   |                | 1 Burial 2 Cremation 3 F   |  |   | matory or other place                         |                                     |   |                    | •  |
| rmit. Pages spartment of portant: If it portant: If it it it it injury or of the contant of the |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Foreral Service Lice  |  | 1   | re Crematori                                  |                                     | /24/2008  | Lewes              | •  |
| Dallimore, Marylia permit. Pages 1 and 2 should permit. Pages 1 and 2 should permit if them 27 is marke important. If them 27 is marke any injury or other traumatic.   |                | 21. digitature di rateral device Ellasis   | 00/  |   | Parsell Fi                                    | uneral                              | Enterprise                                      | es, Inc            |  |
|   | -              | 23a Part 1 Enter the disease   | ications the sourced t                               |   |   |                                     | way, Lewes                                      |                    | 19958  |
| Physician   |                | 23a. Part1. Enter the di ease, shock, or heart tillure. List only o<br>Immediate Cause (Final disease or condition resulting in death)   | ne cause of each line<br>a. Subdu                    | 107-0-1401                                    | natema  | , suomas cardi                      | ac or respiratory are                           | si,                | Approximate Interval Between Onset and Death L_day                 |
| /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a                                      | consequence of):                              |   |                                     | 1/1   |                    |  |
|   | -              | Se wentially list conditions,  | Bilater  | consequence on:                               | nonary t                                      | zmboli.                             | m   | CADO               | 1717 )   |
| ed sit  | ine            | Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (of as a                                      | consequence or).                              | ,   | /                                   | A TONYME  | DICALEXAMI         | AEI  |
| xecur<br>and<br>Il-trar   | Examine        | that initiated events resulting in death) Last   | Due to (or as a                                      | consequence of):                              |   | CERTIFICA                           | TOU APPROVED BY ME                              |                    |  |
| oorou,<br>icate be executed<br>physician and<br>s the burial-transit  | <u>е</u>       |  | 2 2 2 12 (2 1 2 2                                    |   |   | OEM                                 | <i>,</i> ,                                      |                    |  |
| phys<br>phys<br>the   | dical          |  | d  |   |   | -                                   | <b>/</b>  |                    |  |
| The coulds, F.O. BOX 80100,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Me   | IF FEMALE:   | 23c. If yes, outcome p                               | of pregnancy                                  |   |                                     |   |                    |  |
| BOX<br>auth cer<br>attendir<br>for use  | ian            | in the past 12 months?   | 1 ☐Live birth 2<br>4 ☐ Pregnant at t                 | Fetal death 3                                 | Ectopic pregnancy                             |                                     |   |                    | ate of delivery<br>onth Day Year                                   |
| the de  | ysic           | 1 ☐ Yes 2 🕱 No<br>9 ☐ Unknown  | 9□Unknown  | illie oi death 5L                             | Other (specify)                               |                                     |   |                    |  |
| hat the delay detac   |                | Part II. Other significant conditions co   | ntributing to death but                              | t not resulting in the u                      | nderlying cause giver                         | n in Part I                         | 23e Did toba                                    | acco use con       | tribute to the cause of death?                                     |
| w requires to been signer should be o   | Completed by   | , and the second | Ů  | <b>3</b>                                      | <b>,,,</b>                                    |                                     | 1 □ Ye  |                    | 3 Probably 4 Munknown  |
| peen requ   | etec           |  |  |   |   |                                     |   |                    |  |
| has the eas   | np(            |  |  |   |   |                                     | 24a. Was an autopsy                             | ·                  | Were autopsy findings available<br>prior to completion of cause of |
| The   | So             |  |  |   |   |                                     | perform<br>1∐ Yes 2                             | ed?<br><b>X</b> No | death?<br>1 ☐ Yes 2 ☐ No   |
| VICIAN: Cician: Certificat  | Be             | 25. Was case referred to medical examiner?   |  |   |   |                                     | eath (Check only one                            | )                  |  |
| Physic rathis of ral dire   | ပ္             | AL IES EXTINO  | lospital:  |   | nt 3 DOA Other                                | r: 4 Nursing                        | Home 5 ☐ Resider                                | nce 6 ⊟Ott         | ner (Specify)  |
| ng P  |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day                   | / 28b. Time o<br><i>Year</i> ) Injury         | f 28c. Injury<br>Works                        | at<br>?                             | 28d. Describe how                               | v injury occur     | rred   |
| r Attending<br>ter death.<br>irector: Afte  | ati            | 2 ☐ Accident investigation   |  |   |   | es 2 □ No                           |   |                    |  |
| r Att   | ţįį            | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of injur<br>building, etc.                | y - At home, farm, str<br>(Specify)           | reet, factory, office                         |                                     | 28f. Location (Stre<br>City or Town,            |                    | ber or Rural Route Number,   |
| ital c  | Certification: |  | //   |   |   |                                     |   |                    |  |
| To the Hospital or Attending Physician: The law requires that the death certify the Hospital or Attending Physician: The law requires that the death certify the Tuneral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as   | ical           | (Check only 2 Medical Exami  | sician: To the best of<br>ner: On the basis of a     | f my knowledge, deat<br>examination and/or in | h occurred at the time                        | e, date and pla-<br>inion, death oc | ce, and due to the ca<br>curred at the time. da | use(s) and m       | anner as stated.<br>and due to the cause(s)                        |
| the I   | Medical        | one)   | and manner state                                     | ed.   |   |                                     |   |                    |  |
| To cor  | 2              | 29b. Signature and title of certifier  |  |   | 29c. License                                  |                                     |   | -                  | ed (Month, Day, Year)  |
| 10,   |                | June   |  | MD  | AU 1176                                       | 435 W                               | 17471 N   | raich              | 20 2008  |
| 1.57  |                | 30. Name and address of person who co  |  |   | Print)  |                                     |   |                    |  |
| U   |                | Ashley Wermir  | OO Detinton  | outh Gr                                       | eene St,                                      | Balt                                | imore N   | ID 21              | 201  |
| Sta<br>Registr  |                | 31. Date filed (Mbnth Day, Year) 5 2   | 008 32. Redistrar                                    | 's Signature                                  | Sall .  |                                     |   |                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 0530 Ella Mae Hummer 24 08 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO Salisbui Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 8. Date of Birth (Month, Day, Year) aug. 28,1933 Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗓 F Hours Director 222-18-7339 Maryland Aug. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f show Examiner must be notified at De. Sussex Director Laurel Y Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene.

Other than "natural", or Items 23a or 19956 403 Laurel Commons USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Garment Factory is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Health and Mental Albert Darby Alice Darby Tull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trainonce. Linda Smith (Daughter) 28298 Beaver Dam Branch Road Laurel, De. 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 \\_Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hebron Cemetery 3-29-2008 Hebron, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Hannigan, Short, Disharoon F.

23a. Part1. Enter & disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART CONFESTIVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.0. ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2X No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 A Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

180

DHMH 17 Rev 1/2001

Registrar

P.R.m.c

100 E. Carroll St. Salisbury m.D. 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

m.D

Chodnicki

MAR 2 6 2008

Dennis

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death HORSEY US 4:45A M JANE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 119 DU MICOMICO 0 200 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 💢 F Days 220-28-0760 11-26-1934 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ] c [d MD ris 1 Yes 2 No OMERSE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A DUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 22-No Specify. 15/ack 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafend Domestic abover Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MES lbert ollins <os:`€ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 S COH ST Vivian usuille 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Hopewell, UD 3-29-08 4 Donation 5 Dother (Specify) Hopeweit 22. Name and Address of Facility Anthony E. Ward Funeral Hemo 314 Cove ST. Crisfield, UD 21817 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. -nd Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform 1□ Yes Mes. 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Physician:

or Vital Records, P.O. Box 68760,

Examiner and burial-trai attending physician

as

use

for

detached

**Physician** 

/Medical

Examiner

Funeral Director

Be Completed by

2

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

y To the Hospital ...
within 24 hours after death.
To the Funeral Director: After this c Udo

Physician/Medical ins certificate has been signed by director, page 2 should be detacl ģ Completed Be Certification: To

Medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a Certifier

and manner stated.

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year) Injury

1 🗍 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 StOther (Specify) Hospica

29b. Signature and title of certifier Tregario

29c. License number

29d. Date signed (Month, Day, Year) 03-23-2008

50. Name end a dress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY, MD 21801
31. Date filed (Month Prop.) 6 2008 32. Registrar's Signeture?

State Registrar

|                   |  |                      | _ FOr  | epartment of Health and N<br>Certificate of Death   | ∕lental Hygieı<br>Reg.                            | _ / H H K   | 11576   |
|-------------------|--|----------------------|--|---|---|---|---|
| ×                 | Physici  |                      | Decedent's Name (First, Middle, Last)     Amanda Marie Hales   |   | 2. Date of Death<br>Month<br>March 23             | Day 2008 ear  | 3. Time of Death 8:35 aM                                  |
|                   | /Medic<br>Examin   |                      | 4a. Facility Name (If not institution, give street and number)  25067 Delmar Road  | 4b. City, Town, or Location of Death Mardela Spri   |   | 4c. County of Death Wicomico                        |   |
|                   | Funeral<br>Director  |                      | 5. Social Security Number 6. Sex 1 M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | Months   Days   Hours   Min   | 8. Date of Birth (Month, Day, Ye 3/9/1933         | ear) Cour   | olace (State or Foreign<br>ntry)<br>aware                 |
|                   | the Maryland<br>728a-f show<br>notified at   | rector               | Usual Residence of Decedent   10a. State   | la Springs 10f. Zip Code  | 10g.  | Citizen of What Cour                                | 0d. Inside City Limits 1 □ Yes 2 □ No htty?               |
| 36                | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director  | 25067 Delmar Road  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:  | 21837  13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2X No Specify:       | pecify Yes or No-<br>p Rican, etc.)               | USA  14. Race - Americ Black, White,  Specify: Whit | etc.  |
| 21215-0036        | d within 72 hou<br>giene.<br>er than "natura<br>the Medical E  | Completed            | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | ecedent's Usual Occupation<br>Give kind of work done during most of work<br>fe. DO NOT use retired)<br>itress/clerk | king  | . Kind of Business/Ind                              | •   |
| Maryland 3        | 12 should be filed v<br>h and Mental Hygie<br>7 is marked other t<br>traumatic event, th   | To Be C              | 17. Father's Name (First, Middle, Last) William Allen Hooper   | 18. Mother's Nam<br>Ruby Tr   | e (First, Middle, Maid<br>uitt                    | den Surname)  |   |
|                   | i 1 and 2 sho<br>Health and<br>tem 27 is mi  |                      | Teresa H. Tudor/daughter 8   | Mailing Address (Street and Number or Ru. 37 Cottonwood Dr.,  | Severna Pa  | ark, MD 21  | 146   |
| Baltimore,        | t. Pa<br>tmer<br>tant:<br>ijury  |                      | 1  Burial 2 □ Cremation 3 □ Removal from State Spring in Spring i  | isposition (Name of grantony or other place)  1111 MelliOLY  3/26  22. Name and Address of Facility                 |   | ebron, MD   | own, State  |
| Bal               | permir<br>Depar<br>Impor<br>any Ir   | 0. 8                 | 22. Signature of Funeral Service Licensee  CFSP  22a Part 1 Enter the disease or complications had caused the death. Do not be a service of the death. Do not be a service of the death. Do not be a service of the death.   | <u>Salisbur</u>   | ssional As<br>y, MD 2180                          | sociation<br>4<br>Approximate                       |   |
|                   | Physician<br>/Medical<br>Examiner  |                      | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of Sequentially list conditions,  | of Urcfer   | or respiratory arross,                            |   | Interval Between Onset and Death                          |
| 8760,             | cate be executed physician and the burial-transit  | dical Examiner       | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of Cause (Disease or injury that initiated events are consequence of Cause (Disease or injury that initiated events are consequence of Cause (Cause of Cause of Caus |   |   |   |   |
| P.O. Box 68       | nding<br>use as  | Physician/Med        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 □Ectopic pregnancy<br>5 □ Other (specify)   |   | 23d. Date of delive                                 | ery<br>Day Year   |
|                   | w requires that the death<br>been signed by the atte<br>should be detached for   | b                    | Part II. Other significant conditions contributing to death but not resulting in t   | ne underlying cause given in Part I.  | 23e. Did tobac                                    | cco use contribute to t                             | he cause of death?<br>pably 4 □Unknown                    |
| al Records,       | n: The law re<br>ficate has bee<br>r, page 2 sho   | Completed            |  |   | 24a. Was an<br>autopsy<br>performer<br>1⊡ Yes 2 A | ? prior to co<br>death?                             | opsy findings available<br>mpletion of cause of<br>2 ☐ No |
| Division or Vital | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Certification: To Be | 25. Was case referred to medical examiner?  1   Yes   Yes   Hospital:   1   Inpatient   2   ER/Outp  27. Manner of Death   28a. Date of Injury (Month, Day Year)   Injury   28b. Tir (Month, Day Year)   Injury   28b. Tir (Month, Day Year)   Injury   28c. Place of injury - At home, farn building, etc. (Specify)  | atient 3 DOA Other: 4 Nursing H ne of   | 28d. Describe how i                               | injury occurred  et and Number or Rure              |   |
|                   | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I   | Medical Co           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/one) and manner stated.  | death occurred at the time, date and place<br>or investigation, in my opinion, death occu                           | e, and due to the caus<br>arred at the time, date | se(s) and manner as s<br>and place, and due t       | stated.<br>to the cause(s)                                |
|                   | To the Complex   | Me                   | 29b. Signature and title of certifier  M   3   | 29c. License number   |   | Date signed (Month,                                 |   |
|                   | DA   |                      | 30. Name and address of person who completed cause of death (Item 23a) (T James E, MARTIN, MP, 115   | ype, Print) E Carroll 51.   | 5.1.550   | , mp.   | 2180,   |
|                   | Sta<br>Registi   |                      | 31. Date filed (Month, Day/Year) MAR 2 6 2008 32. Registrar's Signature  |   |   | ,   |   |

DHMH 17 Rev 1/2001

ORIGINAL

|                            |  |                  | For<br>State<br>Registrar   |                                |  |  | d / Depa                       |                              | of H                        | ealth a                    |               | lental Hyg                              |                          | 008                         | Manufacture (          | 577                   |
|----------------------------|--|------------------|---|--------------------------------|--|--|--------------------------------|------------------------------|-----------------------------|----------------------------|---------------|---|--------------------------|-----------------------------|------------------------|-----------------------|
|                            |  |                  | 1. Decedent's Name (F   | īrst, Middle, Las              | it)  |  |                                |                              |                             |                            |               | 2. Date of Deat                         |                          | Vone                        | 3. Time                | of Death              |
|                            | Physic   |                  | Pearl   | Joseph                         | nine He  | rbert  |                                |                              |                             |                            |               | March 3                                 | 1, 20                    | 008 Year                    | 11:4                   | 10 Am                 |
|                            | /Medi<br>Examii  |                  | 4a. Facility Name (If no  | <del>-</del>                   |  |  |                                | 4b. City,                    | Town, or                    | Location o                 |               |   |                          | unty of Death               | 7                      |                       |
| 1                          |  |                  | 18934 MI  | ddletc                         | own Roa  | đ  |                                | Par                          | kto                         | n                          |               |   | Ba:                      | ltimo                       | re                     |                       |
|                            | Funeral  |                  | 5. Social Security Numb   | per 6. Se                      | ex 7.  | Age (In yrs. la  | st birthday)                   | If Under                     | 1 Year                      | If Under                   |               | 8. Date of Birth<br>(Month, Day,        | 1                        |                             |                        | te or Foreign         |
|                            | Director   |                  | 217-28-5  | 784                            | ☐M 2ሺ F  | 75   | Yrs.                           | Months                       | Days                        | Hours                      | Min.          | NOV. 6                                  | 1932                     | Mar                         | ylan                   | d                     |
|                            | D  |                  | Usual Residence of De   |                                |  |  |                                | l                            |                             |                            |               |   |                          |                             | 7 =                    |                       |
|                            | ylan   |                  | 10a. State 10   | b. County                      |  | 10c. City,   | Town or Lo                     | cation                       |                             |                            |               |   |                          |                             | 10d. Inside            | City Limits           |
|                            | Ma<br>F  | ş                | MD E  | Baltimo                        | ore  | Pa   | arkto                          | n                            |                             |                            |               |   |                          |                             | 1 □ Y                  | es 2X No              |
|                            | 1 28 r   | <u>ř</u>         | 10e. Street and Numbe   | r                              |  |  |                                | 10f. Zip                     | Code                        |                            |               | 1                                       | 0g. Citizer              | of What Co                  | untry?                 |                       |
|                            | 3a o   | Funeral Director | 18934 Mi  | ddleto                         | own Roa  | d  |                                | 2                            | 112                         | 0                          |               |   | USA                      |                             |                        |                       |
|                            | me 2   | era              | 11. Marital Status  |                                | 12. Was Decede   | ent Ever in U.S  | 3. 13.1                        | Was Deced                    | ent of Hi                   | spanic Orig                | gin? (Spe     | ecify Yes or No-<br>Rican, etc.)        | 14.                      | Race - Amer                 |                        | i,                    |
| (0                         | The state of the s | 교                | 1 Never Married   | 2 Married                      | Amed Force 1 ☐ Yes 2                                   |  |                                |                              |                             |                            | , Puerto      | Rican, etc.)                            |                          | Black, White                |                        |                       |
| 80                         | urs a<br>al', o<br>Eran  | b                | 3 X Widowed 4 □   | ]Divorced                      | If Yes, Give<br>Year or Date                           | os:  |                                | 1 ☐ Yes 2                    | No No                       | Specify:                   |               |   | Sp                       | ecify: W.                   | hite                   |                       |
| 21215-0036                 | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Itema 23a or 28a-1 ehow<br>tha Medical Examinar must be notified at  | Completed by     |   | Decedent's Ed                  |  |  | 16a. Dece                      | dent's Usua                  | I Occupa                    | ition                      |               |   | 16b. Kind                | of Business/l               | ndustry                |                       |
| 7                          | n n  | ple              | (Specify of Elementary/Seconda  | only highest grad              | de completed) College (1-4)                            | or 54)   | (Give<br>life. i               | kind of wor<br>DO NOT us     | k done d<br>e retired,      | u <i>ring</i> mosi<br>)    | of worki      | ng                                      |                          |                             |                        |                       |
| 7                          | filed withi<br>Hygiene.<br>other than  | E O              | 12  | ., (0 12)                      | College (1.4   | 01 547   | Caf€                           | eteri                        | a M                         | anag                       | er            |   | Edu                      | catio                       | n                      |                       |
| g                          | should be filed<br>ad Mental Hygis<br>marked other<br>matic event, I   | BeC              | 17. Father's Name (Firs   | t, Middle, Last)               |  |  |                                |                              |                             | 18. Mothe                  | r's Name      | (First, Middle, M                       | <i>Maiden S</i> u        | mame)                       | -                      |                       |
| <u>a</u>                   | Mental Mental arked o  | To B             | Worley  | Dix                            |  |  |                                |                              |                             | Ne                         | $11i\epsilon$ | Goodn                                   | an                       |                             |                        |                       |
| Maryland                   | d 2 should be filed within th and Mental Hygiene. 77 is marked other than treumatic event, the Ms  | -                | 19a. Informant's Name   | /Relationship (7               | ype, Print)  |  | 19b. Mailir                    | ng Address                   | (Street a                   |                            |               | I Route Number                          |                          | own, State, Z               | ip Code)               |                       |
| ž                          | nd 2 state at 27 is ritrou   |                  | James F.  | Herber                         | t.Jr.,   | Son  | 316                            | Gady                         | wal:                        | L Cou                      | rt.           | Havre de                                | Grad                     | e. MD                       | 21078                  | 3                     |
| ē,                         | f Heelt<br>frem 2<br>other   |                  | 20a. Method of Disposi  | tion                           |  | 20b. Pla   | ace of Dispo<br>metery, crer   |                              |                             | .                          | C             | ate                                     |                          | tion - City or T            |                        |                       |
| 9                          | Pages<br>nent of I<br>ant: If Its<br>ary or o  |                  | 1 🖾 Burial 2 🗆 C<br>→ 4 □ Donation 5 [  |                                |  |  | metery, crer<br>blers          |                              |                             |                            | Apri<br>200   | 14,                                     | Dark                     | ton,                        | WD                     |                       |
| Baltimore,                 | permit. Pag<br>Depertment<br>Importent: I<br>eny Injury o  | 1                | 21. Signature of Faner  |                                |  | , , ,  |                                |                              | _                           |                            |               | J. Harte                                |                          |                             |                        | Tnc                   |
| Ba                         | permit. Pages Depertment of Important: If I eny Injury or  |                  | 23a. Part1. Enter the d   | J. He                          | rteust   | end  | 74                             | 24 Sec                       | cond                        | St.                        | , Ne          | w Free                                  | dom,                     |                             |                        | y, IIIC               |
| 760,                       | /Medical was been at a part of the burial-transit was the burial-transit was the property of the burial-transit was the burial-transit was the burial-transit was the burial-transit was the beautiful of the burial was | Ical Examiner    | Immediate Cause (Findisease or condition resulting in death)  Sequentially list condition ray, leading to aimmediate, leading to aimmediate. Enter Underlying Cause (Disease or injuthat initiated events resulting in death) | ions,<br>diate<br>ng           | b. Due to (or c.                                       | as a consequence of the conseque | ence of):  CLA  ance or):  E A | rosi                         | S                           | ∪ FA                       | nc            | TION                                    | )                        |                             | MED                    | I ATE<br>LATE<br>EARS |
| . Box 68                   | death certific<br>e attending pl<br>id for use as I  | Physician/Medi   | IF FEMALE: 23b. Was decedent prein the past 12 moi 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown  | nths?                          |  | n 2 ☐ Fetal of<br>tat time of de   | death 3□                       | Ectopic pre                  |                             |                            |               | ***                                     | 230                      | I. Date of delined Month    | very<br>Day            | Year                  |
|                            | signed<br>d be de  | 6                | Part II. Other significan   | nt conditions co               | ontributing to deat                                    | h but not resul  | lting in the u                 | nderlying ca                 | luse give                   | n in Part I.               |               | 23e. Did tob                            |                          | contribute to               |                        | of death?             |
| COL                        | s been<br>s shoule   | olete            |   |                                |  |  |                                |                              |                             |                            |               | 24a. Was a                              | 1 2                      | 4b. Were au                 | topsy findin           | gs available          |
| E Re                       |  | Completed        |   |                                |  |  | <del></del>                    |                              |                             |                            |               | autops<br>perform<br>1 Yes 2            | ned?                     | death?                      | completion of 2 No     | of cause of           |
| /ita                       | Physician: Th<br>this certificete<br>ral director, pag   | Be               | 25. Was case referred examiner?   | -                              |  |  |                                |                              |                             |                            | of Death      | (Check only on                          | 8)                       |                             |                        |                       |
| $\leq$                     | hysicia<br>this cert<br>at direct  | ၉                | 1 ☐ Yes 2 No  |                                |  | atient 2 🗆 E   | R/Outpatien                    |                              | 444                         | 7 140                      | rsing Hor     | ne 5 <b>≻ ne</b> side                   | nce 6                    | Other (Spec                 | cify)                  |                       |
| ion                        | fe fe  | atlon;           | 27. Manner of Death 1 Natural 5 2 □ Accident  | ☐ Pending investigation        |  | njury<br>Day Year)   | 28b. Time of<br>Injury         | M 28                         | 3c. Injury<br>Work<br>1 □ \ | at<br>?<br>′es 2 □!        |               | 28d. Describe ho                        | w injury o               | ccurred                     |                        |                       |
| Division of Vital Records, | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Certification;   | 3 ☐ Suicide 6<br>4 ☐ Hornicide  | Could not be determined        | 286. Place of  | Injury - At hor<br>, etc. (Specify)  |                                | eet, factory,                | , office                    |                            | *             | 28f. Location (St.<br>City or Town      |                          | lumber or Ru                | ral Route N            | lumber,               |
|                            | Hospite<br>24 hours<br>Funera  | edical C         | 29a. Certifier 15<br>(Check only 25<br>one)   | Certifying Phy<br>Medical Exam | ysician: To the be<br>liner: On the basi<br>and manner | s of examination   | rledge, death<br>on and/or in  | n occurred a<br>vestigation, | at the tim<br>in my op      | e, date and<br>inion, deat | d place, a    | and due to the ca<br>ed at the time, da | use(s) an<br>ate and pla | d manner as<br>ace, and due | stated.<br>to the caus | e(s)                  |
|                            | of this of the office of the o | Me               | 29b. Signature and title  | of certifier //                | 2  |  |                                | 29c.                         | License                     | number                     |               | 2:                                      | 9d. Date ş               | igned (Month                | n, Day, Year           | r)                    |
|                            | > 0  |                  | $\rightarrow$   |                                | 1  |  | 3                              | D                            | 00                          | 181                        | 662           | _                                       | 4/                       | 1/20                        | 800                    |                       |
| •                          |  |                  | 30. Name and address  | of person who                  | completed cause of                                     | of death (Item   | 23a) (Type,                    | Print)                       | M.A                         | ?                          | 121           | - Sistu                                 | Rie                      | rie                         | Day .                  |                       |
|                            | Sta  |                  | 31. Date filed (Month, L  | Day, Year)                     | 32. Reg  | istrar's Signatu   | nte D                          |                              |                             |                            | . 010         | 45-0-0                                  | 0                        |                             |                        | SHE FE                |
|                            | Regist   | rar              | NDD   | 0 9 200                        | 8 12000  | . 1  | A GOA                          |                              |                             |                            |               |   |                          |                             |                        |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 23° 2008 ear 7:25p M **Physician** Morrison Jenkins Jean /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery 1102 Allison Drive If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday 8 Date of Birth Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days 84 Months *1<sup>M</sup>*777971<sup>M</sup>924 1 □ M 2 🔀 F 031-16-9416 Massachusetts Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Rockville 1X Yes 2 No Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1102 Allison Drive 20851 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Clerk Elections Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur H.Morrison Lucy E.Besse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William M.Jenkins/Son 1102 Allison Drive Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 Removal from State 3/31/2008 Center Cemetery Wareham, MA. 4 Donation 5 Other (Specify) 21. Signal of Funeral S PHITIPADS RINGALDI FUNERAL SERVICE, P.A. icens 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) End stage renal disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed and-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending pl 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 💆 No Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown advanced microvascular dementia Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No septicemia page 2 s autopsy performed? Yes 2 No has this certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ို funeral 28a Date of Injury 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: (Month, Day Year) Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. Lîcense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P D0064615 March 25,2008 0

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

o

Division or Vital Records, P.

1355 Piccard Drive Rockville, Md 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Génevieve

MAR

26

31. Date filed (Month, Day, Year)

Wroblenski MD

32 Registrar's Signature

08-02290 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey L. Jones State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day March 23, 2008 1038 hrs **Medical Examiner** ones 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Wicomico Peninsula Regional Medcical Center Salisbury If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Davs Hours Min Director 5/3/ Country) 216-76-267) 1 **X** M 2 F ٧rs Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location Yes 2 No or items 23a or 28a-f show i com ico traumatic event, the Medical Examiner must be notified at once, Director 10g, Citizen of What Country 10e. Street and Number 10f. Zin Code 29136 Santa Fe Drive 21801 TISA Funeral 14. Race - American Indian. Black. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married 1 Never Married 2 3 Yes Specify: Dlact 2 No specify: If Yes, Give Yea Widowed Divorced Yes 4 item 27 is marked other than "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n upervisor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be sones Sar 010 bara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date operant or y or other tr crematory or other place) 1 Burial 2 Cremation Removal from State 3 hance. Donation 5 Other Specify: 22. Name and Address of Facility ed Service Licenses 917 W. Isabella Straut-Sal Sm disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Enter the Physician Between Onset and re. List only one cause on each line 'Medical Death Complications of intracerebral hemorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED X AMENDED attending physician or use as the burial erFh.1.P 1-2. P2. 27 perME.g879 5/12/08 TT Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did topacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 ✓ No 3 Probably 4 Unknown Cardiomegaly with left ventricular hypertrophy and biventricular Completed 24b. Were autopsy findings available page 2 should 24a. Was an dilatation prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2\_ 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical funeral director. Division of Vital Be Hospital: Other<sub>4</sub> Other this ( Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ို 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fur 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number

op

State Registrar O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 24, 2008

Melissa Brassell, MD

31. Date filed (Month Clay,

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

32. Registrar's Signature

|                 |  |                | For<br>State  | end#2.Peri                           |                                  |  | -                                 |  | artmen<br><i>rtificat</i>   |                        |                        |                           | ntal Hyg<br>F                            | giene<br>Reg. No. (       | 2008                              | garden applicated on the party of the party | 580                         |
|-----------------|--|----------------|---|--------------------------------------|----------------------------------|--|-----------------------------------|--|-----------------------------|------------------------|------------------------|---------------------------|--|---------------------------|-----------------------------------|---|-----------------------------|
|                 | Physicia   |                | 1. Decedent's Nam   | ne (First, Middle                    | , Last)                          |  |                                   |  |                             |                        |                        | 2                         | Date of Dea                              | oth<br>Day                | 16, <u>2</u> %68                  | 3. Time o   | M                           |
|                 | /Medic   | al             | JAMES M 4a. Facility Name (   |                                      |                                  |  |                                   |  | 4b. City,                   | Town, or               | Location               | of Death                  | 03/15                                    | 4c. C                     | ounty of Death                    | 1:28  | Р "                         |
|                 | Examin   | er             | 7825 RIV  |                                      |                                  |  | 03                                |  |                             |                        | ROLLT                  |                           |  |                           | NCE GEO                           |   |                             |
| - <del></del> , | Funeral<br>Director  |                | 5. Social Security 1<br>220–56–6  | 639                                  | 6. Sex<br>1X M 2                 | 7. Ag  | e (In yrs. I                      | ast birthday, Yrs.                     | if Under<br>Months          | 1 Year<br>Days         | If Under<br>Hours      | Min.                      | B. Date of Birt<br>(Month, Day<br>01/07/ | v, Year)                  | Cou                               | place (State<br>intry)<br>HINGTO  |                             |
|                 | land<br>ow<br>ft   |                | Usual Residence of<br>10a. State  | 10b. County                          |                                  | _  | 10c. City                         | , Town or L                            | ocation                     |                        |                        |                           |  |                           |                                   | 10d. Inside C   |                             |
|                 | Marylan<br>a-f show<br>ified at  | tor            | MD  | PRINCE                               | GEORGI                           | ES   | NEW                               | CARRO                                  | LLTON                       | ı                      |                        |                           |  |                           |                                   |   | s 2 No                      |
|                 | th the or 28g  | Director       | 10e. Street and Nu  |                                      |                                  |  |                                   |  | 10f. Zip                    |                        |                        |                           |  |                           | en of What Cou                    | intry?  |                             |
|                 | ath wi   | ral            | 7825 RIV  | ERDALE                               |                                  | PT.# 3   |                                   | S 13                                   | Was Dace                    |                        | lisnanic O             | rigin? (Spec              | ity Yes or No                            | USA<br>14                 | 4. Race - Amer                    | ican Indian,  |                             |
|                 | 2 should be filed within 72 hours after death with the Manyland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show armatic event, the Medical Examiner must be notified at | by Funeral     |   | rried 2 Marr<br>4 Divorced           | Arm                              | ed Forces?<br>Yes 2X11<br>es, Give<br>r or Dates:  |                                   | 3.                                     | if Yes, spe                 |                        | Specify                |                           | ity Yes or No<br>ican, etc.)             | 1                         | Black, White                      |   |                             |
| 5               | 72 hol<br>"natur<br>idical E   | Completed      | (Spe  | 15. Deceden                          | t's Education<br>st grade comp   | eted)  | il                                | 16a. Dece                              | edent's Usu<br>e kind of wo | al Occup<br>ork done   | ation<br>during mo     | st of workin              | g  | 16b. Kin                  | d of Business/l                   | ndustry   |                             |
| 7               | within<br>ene.<br>than he Me   | dwc            | Elementary/Sec  | condary (0-12)                       | Coll                             | ege (1-4or 5                                       | 5+)                               | 1                                      | OUSEN                       |                        | -,                     |                           |  | PRIV                      | ATE                               |   |                             |
| 2               | e filed<br>Il Hygi<br>other<br>ent, t  | BeC            | 17. Father's Name   | e (First, Middle,                    | Last)                            |  |                                   |  |                             |                        |                        |                           | (First, Middle                           |                           | Surname)                          |   |                             |
| <u></u>         | uld be<br>Menta<br>arked<br>atic ev  | To E           | JAMES AR  | тник ло                              | HNSON                            |  |                                   |  |                             |                        |                        |                           | NN JON                                   |                           |                                   |   | _                           |
| 0               | 2 sho<br>land<br>ls ma<br>rauma  |                | 19a. Informant's N  |                                      |                                  | nt)  |                                   |  |                             |                        |                        |                           |  |                           | Town, State, 2                    |   |                             |
| ב<br>ע          | 1 and<br>Health<br>em 27<br>ther tu  | _              | NICOLE B  |                                      | UGHTER                           |  | 20b. F                            | 17825<br>Place of Disp<br>cemetery, ch | RIVER<br>position (Na       |                        |                        |                           | #303 N                                   |                           | RROLLT(<br>ation - City or        |   | 2078                        |
| 2               | Pages<br>nent of h<br>int: If ite  |                | 1 XBurial 2   | 2 ☐Cremation<br>5 ☐Other (5          |                                  | from State   |                                   | cemetery, cr<br>RMONY                  |                             |                        | ce)                    | 03/26                     | /2008                                    | LANDO                     | OVER, M                           | D   |                             |
|                 | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic et one.   |                | 21. Signature of F  |                                      |                                  | 11.  |                                   | - 11:                                  | 22. Name a                  | nd Addre               |                        | ility J.B                 | . JENK                                   | INS F                     | UNERAL                            | HOME  |                             |
| Ŏ               | De la  |                | MIM   | WAI                                  | lain                             | MIK  |                                   |  |                             |                        |                        |                           |  | -                         | D 2078                            |   | nata                        |
|                 |  |                | 23a. Part1. Enter<br>shock, or he   |                                      | r complications<br>only one caus | that cause<br>e on each li                         | d the deat<br>ine.                | h. Do not e                            | nter the mo                 | de of dyi              | ng, such a             | as cardiac o              | r respiratory a                          | irrest,                   |                                   | Approxim<br>Interval B<br>Onset an  | etween<br>d Death           |
|                 | Physician /Medical   |                | Immediate Cause<br>disease or condit<br>resulting in death  | tion                                 |                                  | RTERI(   |                                   | ROTIC                                  | CARD                        | LOVA                   | SCUL                   | AR DIS                    | EASE                                     |                           |                                   | 1 MON   | TH                          |
|                 | Examiner   |                |   |                                      |                                  | iue to (oi as                                      | a conseq                          | juerice or/.                           |                             |                        |                        |                           |  |                           |                                   |   |                             |
| S               |  | ner            | Sequentially list of if any, leading to cause. Enter Und Cause (Disease of Cause of | conditions,<br>immediate<br>derlying | <b>)</b> b                       | ue to (or as                                       | a conseq                          | quence of):                            |                             |                        |                        |                           |  |                           |                                   |   |                             |
|                 | ecuted<br>and<br>-transf   | Examiner       | Cause (Disease of that initiated ever resulting in death  | าเร                                  | c                                | ue to (or as                                       | a consec                          | nuence of):                            |                             |                        |                        |                           |  |                           |                                   |   |                             |
| 8/00,           | icate be executed<br>physician and<br>s the burial-transit   | al E           | 3   |                                      |                                  | , do to to to ac                                   |                                   | ,                                      |                             |                        |                        |                           |  |                           |                                   |   |                             |
| 00              | fficate<br>g phys  | edical         |   |                                      | d                                |  |                                   |  |                             |                        |                        |                           |  |                           |                                   |   |                             |
| O. BOX          | w requires that the death certificate be executed<br>been signed by the attending physician and<br>should be detached for use as the burial-transit  | Physician/M    | iF FEMALE: 23b. Was deceded in the past 1 1 ☐ Yes 2 9 ☐ Unknow  | 12 months?<br>2 □ No                 | 1                                | es, outcome<br>Live birth<br>Pregnant a<br>Unknown | 2 Fet                             | al death 3                             | l⊟Ectopic<br>i⊟Other (s     |                        | у                      | _                         |  | 2                         | 23d. Date of de<br>Month          | livery<br>Day   | Year                        |
| 7.              | requires that the<br>een signed by the<br>nould be detache   | by Ph          | Part II. Other sig  |                                      | ions contributi                  | ng to death l                                      | but not res                       | sulting in the                         | underlying                  | cause gi               | ven in Pa              | rt I.                     |  | _                         | se contribute to                  |   |                             |
| ğ               | equire<br>en sig<br>ould b   | ed b           | HYPERTE   | ENSTON                               |                                  |  |                                   |  |                             |                        |                        |                           | 1  | Yes 2                     | X1 No 3 □ P                       |   |                             |
| Hecords         | at co oi   | Completed      |   |                                      |                                  |  |                                   |  |                             |                        |                        |                           | 24a. Was                                 | s an<br>opsy<br>formed?   | 24b. Were a prior to death?       | utopsy finding<br>completion o  | gs available<br>if cause of |
|                 | Th<br>ate<br>pag   |                |   |                                      |                                  |  |                                   |  |                             |                        |                        | (D. 11                    | 1□ Yes                                   | 2 🗓 No                    | 1 ☐ Yes                           | 2 <b>X</b> No   |                             |
| Vital           | Physician:<br>this certific<br>ral director,   | Be C           | 25. Was case ref<br>examiner?<br>1 XYes 2   |                                      | Hospita                          | l: 1 □ Innat                                       | ient 2F                           | <br>]ER/Outpat                         | ient 3□ (                   | OA Ot                  |                        |                           | ne 5 <b>X</b> 1 Res                      |                           | 6 □Other (Spe                     | ecify)  |                             |
| ō               | g Physer this eral di  | n: To          | 27. Manner of De  | eath                                 |                                  | . Date of Inj                                      | jury                              | 28b. Time                              | of                          | 28c. Inju              |                        |                           | 28d. Describe                            |                           |                                   |   |                             |
| io<br>io        | tending leath. tor: After the funer  | atio           | 1 ☐XNatural<br>2 ☐ Accident   |                                      | tigation                         |  |                                   |  | М                           | 1[                     | ∃Yes 2                 |                           |  | _                         |                                   |   |                             |
| UIVISION        | l or Attendatter deatt<br>Director:  | Certification: | 3 ☐ Suicide<br>4 ☐ Homicid  | 6 ☐ Could<br>deter                   | mined 286                        | e. Place of in<br>building, e                      | njury - At h<br>etc. <i>(Spec</i> | nome, farm,<br>ify)                    | street, facto               | ory, office            |                        |                           | 28f. Location<br>City or To              | (Street an<br>own, State  | d Number or F                     | rurai Houte N   | umber,                      |
|                 | pita<br>ours<br>eral<br>filled   | Medical Ce     | 29a. Certifier<br>(Check only<br>one)   | 1 Certify<br>2 Medica                | i Examiner: C                    | : To the bes<br>in the basis<br>and manners        | of examin                         | nowledge, de<br>nation and/or          | ath occurre<br>investigati  | ed at the<br>on, in my | time, date<br>opinion, | and place,<br>death occur | and due to th                            | e cause(s)<br>e, date and | ) and manner a<br>d place, and du | s stated.<br>le to the caus   | se(s)                       |
|                 | To the Hos<br>within 24 ha<br>To the Fun<br>completely   | Me             | 29b. Signature a  | and title of certif                  | er athe                          | ev .   | · m ·                             | D                                      |                             | 9c. Licer<br>D476      | 04                     | er                        |  |                           | te signed <i>(Mor</i><br>H 18, 2  |   | r)                          |
| A               | 15   |                | 30. Name and ad SOBHAN  | ddress of perso                      | n who complet $M \cdot D$ .      | ed cause of 3048                                   | death (Ite<br>MITCH               | em 23a) (Typ<br>HELLVI                 | e, Print)<br>LLE R          | OAD                    | BOWI                   | E, MD                     | 20716                                    |                           |                                   |   |                             |
|                 | St<br>Regis  | tate<br>trar   | 31. Date filed (M   | 1 2008                               | r) Real                          | 32. Regis  | trar's Sign                       | ature                                  |                             |                        |                        |                           | -1                                       |                           |                                   |   |                             |
|                 |  |                | MMU &   | 1 2000                               | A CONTRACTOR                     | 7  | 7                                 |  |                             |                        |                        |                           |  |                           |                                   |   |                             |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 5:00 03/16/2008 Jackson, Jr. Warren /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Riderwood Nursing Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1**⊠**M 2□F Washington, DC 03/02/1923 Director 577-22-2655 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt; If item 27 is marked other than "naturar", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r 28a-f show notified at 1X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number items 23a or 2 ner must be n 20018 4312 21st Street, N.E. Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ral", or item Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: چ و 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Fireman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Jackson, Sr. <u>Anna Mae Buckner</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6900 Robinia Road Camp Springs, MD Audrey Powell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 03/24/2008 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Montgomen peathan 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician Arrhythmia /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Hypothyroidism and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis autopsy performed? page 1 Yes 2 No 2√ No this certificate Dementia or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 🖺 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident s after death the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

R [3]

State Registrar 31. Date filed (Month, Day, Year) MAR 2 1 2008

Gracefie



Sachelle M. alexion MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D44156

2008

Rachelle Alexion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] § Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Jones Physician JE.RONA 2008 Marc /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death 4h. City. Town, or Location of Death Examiner Hicanico 3A/Isburi 10 KHAL Medens Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 K F Days 7*2* Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Show ra!", or Items 23a or 28a-f shov Examiner must be notified at Wicomico 1 □ Yes 2 No by Funeral Director 10g. Citizen of What Country? 18 esterville 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify. Specify: 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education studian Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evans SaraH Dashields ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303397 Mallard dr. delmar, mq Dean Evans Jones (SON Baltimore. 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If Ite
any Injury or ot 3 Removal from State Elzies umc Cem. 3-29-08 9-08 Jesterville, md Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith 21. Signature of Funeral Service Licensee Salisbury, md 21801 FUNERAL Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1□ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by enternia 1 Tes 2

No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 KER/Outpatient 3 DOA ō 28a. Date of Injury 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 1450497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. Salisbury, MO 21801 christopher 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) March 23, Day 2008 **Physician** 9:30 Virginia Adelaide James /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Ocean Pines 15 Fishing Creek Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🗙 F 577-24-5224 4/29/1923 Washington, 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a, State 1 XYes 2 □ No Director Ocean Pines Worcester Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 15 Fishing Creek Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 XWidowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) medical practice office administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelaide Perkins Reginald Truman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2460 Lakeside Circle, Livermore, CA 94550 Ryan J.James/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/08 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association David H. Dompor 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Comboursalor acritout **Physician** /Medical Due to (or as a consequence of): Examiner Demonta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and is the burial-transit law requires that the death certificate be executed Upper 62 b 00 Due to (or as a consequence of) Box 68760 Physician/Medical DS attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Hypernationia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an INJUFFE cate has l autopsy performe 1 ☐ Yes 2 No certificate 1∐ Yes 2 No A. Lib ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/eutpatient 3 □ DOA 1 ☐ Yes 2 No 1 🔲 Inpatient ပို After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation Natural within 24 hours after decent of the Funeral Director: Aft 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40066462 3-25-68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10514 Race Track Road Unit C Berlin, mo ZISII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 26 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MATR **Physician** 2008 10:50 AM Emanuel Jackson, Jr. /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death Examiner AGNES HOSP MARYL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F Director 411-70-1810 Illinois March8, 1945 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location works ! 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1√2 Yes 2 No Director Tennessee Shelby Memphis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1649 Latham Street 38106 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Owner Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( ၉ Emanuel Jackson Floria Molett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnetta Jackson/Wife 1649 Latham Street, Memphis, Tennessee 38106 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) New Park Cemetery 4-5-08 Memphis, Tennessee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muchael pursull 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical 2 DAVS STROKE Examiner Sequentially list conditions, if any, loading to induction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 res 2 No 3 Probably 4 Unknown HYPERT ENSION Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Division or Vital 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) CATON AVE 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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JACKSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Herman Paul Kalkowski March 18, 2008 6:35a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 25, 1938 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 1<del>X</del>XM 2□ F Mar VI and 69 217-38-4474 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notifled at XXYes 2□No Director Maryland | Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20872 25001 Woodfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1961 — If Yes, Give Year or Dates: 1963 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married or i <sub>Specify:</sub>White 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hinportant: If Item 27 is marked ott any Injury or other traumatic even once. Be Helen Marie Poremski Herman Kalkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20808 Merle Drive, Gaithersburg, MD 20882 Vielka Massenburg-Personal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brentwood, MD Fort Lincoln Crematory 3-31-08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike ND Rockville, andyn -lisch 23a, Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minutes Acute Pulmonary Embolus /Medical Due to (or as a consequence of) **Examiner** Hypercoaguable State Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disc to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Years <u>Colon Cancer</u> and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🐴 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 After this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 2√ ER/Outpatient 3 DOA 1 XYes 2 ☐ No Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760 within 24 hours a

Baltimore, Maryland 21215-0036

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 18-08

ROCKULLE MO 21850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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JASUN 31. Date filed (Month, Day, Year)

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State

29b. Signature and title of certifier

ARNEC

31. Date filed (Month, Day, Year)

12020

29c. License number

OLD LINE CTR. STE SOV

29d. Date signed (Month, Day, Year)

WACROPF, MD 2660 2

3/24/08

and manner stated.

(AD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Regionar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** Year Ralph Graylon Kitchens 1615 M 22 2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Coastal Hospice at the Lake alispur Wicanico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1/16/1954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**⊠** M 2□ F 219-62-9034 Maryland **Director** 54 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If Item 27 is marked other than "natural", or Items 23a or or other traumatic event, the Medical Examiner must be 1 204 Walden Drive 21826 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 🙀 Divorced white 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 contractor construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve Ralph Kitchens Lydia Phillips ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Kitchens/son 5720 Dockside Rd., Marion, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 3/25/08 Salisbury, MD 21. Signature of Funeral Service Licensee Name and Address of Facility Holloway Funeral Home Professional Association Kell 82 llene 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or us a consequence of): The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 1 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HES Pice Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred after death. Director: After 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

aylon

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 32. Registrar's Signature 6

29c. License number

29d. Date signed (Month, Day, Year)

03-22-2008

State Registrar

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIDYASAGAR ANMANGANDLA

31. Date filed (Month, Day, Year)

APR 0 9 2008

ANMANGANDLA

Registrar's Signature

10583 THEODORE GREEN BLUD

PLAINS,MD-2069S

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUISE 8:30 PM LLOYD MAR 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MINUE REGISTER HOSPITAL LAUREZ G 35266 8. Date of Birth (Month, Day, Y April 15, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** . 1926 Months Days Hours Min. 1 □ M 2 🖾 F 81 Iowa Director 577-30-1295 Usual Residence of Deceden t be notified at 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or amy loury or other traumatic event, the Modral Examiner must be a must be a my loury or other traumatic event, the Modral Examiner must be a must be a most bear and a must be 1225 Kathryn Road U.S.A. 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget & Financial Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emil Venz Natta Arbothnoth ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Lloyd, Jr. - Husband 1225 Kathryn Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial |2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 03/31/2008 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign - Fun ral Service Vic Jakel 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the discret, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition AUUTE **Physician** MESPIRATING 5 days resulting in death) /Medical Due to (or as a consequence of) Examine pnewwona 10 days Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine death certificate be executed ig physician and as the burial-trar Due to (or as a consequence of) Box 68760 Completed by Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) P.O. I ned by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? or Vital Records, 122113 MERS DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MYGODYSPLASTIC SYNORME 24a. Was an autopsy performed? page certificate ANGMIA UMMIC からるみらら 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 □ Impatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eli 1736974 March 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · 10724 UTTLE PATURENT DKWY 0. HAYMINN WD COLUMBIA hus 20044 32 egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Christine Murphy Augusta March 29, 12:41 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 10,1921 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday Days Hours Min. 1 □ M 2 🖾 F 391-12-1572 86 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 26400 Meadow Wood Drive 20659 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 25 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator U.S. Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Sadowska Dix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen A. Montgomery/Daughter 26400 Meadow Wood Dr., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State St. Ignatius 4/5/2008 Port Tobacco, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, M00817 MD 20622 23a. Part1. Enter be disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Qo not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uomd as a consequence of): Due to (o nemio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last nsequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4 □ Pregnant at time of death a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show deal Examiner must be notified at

than

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If Item 27 Is marked other

or other traumatic

injury

any

Director

Funeral

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Completed

Be

2

the Maryland

filed within 72 hours after death with t Hygiene.

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed and attending physician

page 2

the

has

this

After

after death

within 24 hours a To the Funeral D

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician/Medical

۵ Completed Be Certification: To

Medical

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

30. Name and a

29b. Signature and title of certifie

3 Suicide

29a, Certifier

State Registrar

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print Omol M. 1) 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated.

074

5 Pending investigation

6 ☐ Could not be

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Leandre

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Physici<br>I Exam  |                  |  |  | Cer         | tificate of                      | f Death      | )                    |               |                              |                                     | 008                     | 1159   |  |  |
|--|------------------|--|--|-------------|----------------------------------|--------------|----------------------|---------------|------------------------------|-------------------------------------|-------------------------|--|--|--|
| I Exam   |                  | Registrar  1. Decedent's Name (First, Middle,                      | -  |             |                                  | , Dout,      |                      |               | 2. Date of De                | Reg. No.<br>ath<br>Day Yea          |                         | me of Death                                  |  |  |
|  | iner             |  | Gary Gat   | es Ma       |                                  | # 6: T       |                      |               | March 29                     | 9, 2008                             | 11                      | 652 hrs                                      |  |  |
|  |                  | 4a. Facility Name (if not institution,<br>45580 Drayden Road       | give street and number)  |             |                                  | Valley       |                      | cation of Dea | atn                          | 4c. County of St. Mary              |                         |  |  |  |
| Funeral  |                  | Social Security Number   | . Sex 7. Age   | (In yrs. la | ast birthday)                    | If Unde      | r 1 Year             | If Under 24h  | lrs. 8. Date of I            | Birth(MM/OO/YYYY                    |                         | e (State or                                  |  |  |
| Director   |                  | 220-80-7402  | 1XM 2F   | 4           | .7 Yrs                           | Month:       | Days                 | Hours M       | in. April                    | 3, 1960                             | Foreign<br>Country)     | Maryland                                     |  |  |
| ž.   | 1                | Usual Residence of Decedent 10a. State 10b. County                 | Т  | 10a City    | Town or Loca                     | tion         |                      |               |                              |                                     | 10d. Inside City Limits |  |  |  |
| 1<br>:0w an  | ١.               | 6 14   | 1  | •           |                                  |              |                      |               |                              |                                     | 1 Yes 2 X No            |  |  |  |
| aryland<br>Sa-f sh<br>at onc   | cto              | Maryland St. Mar<br>10e. Street and Number                         | ly S   | V &         | alley I                          | 10f. Zip     | Code                 |               |                              | 10g. Citizen of Wh                  |                         |  |  |  |
| permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | 45580 Drayden B  | Road   |             |                                  |              | 2069                 | 2             |                              | Ţ                                   | JSA                     |  |  |  |
| h with<br>ms 23<br>be no   | eral             | 11. Marital Status   | 12. Was Decedent   | Ever in U.  | S. 13. W                         | as Decede    | nt of Hispa          | nic Origin? ( | Specify Yes or I             | No- 14. Race                        | - American Ir           | ndian, Black,                                |  |  |
| or ite   | ᇤ                | 1 X Never Married 2 Mar  | 1 Yes 2  | X No        |                                  | Yes 2        |                      |               | to recarr, etc.,             |                                     |                         |  |  |  |
| rrs afte<br>ural",<br>miner  | by               | Widowed 4 Oivor  15. Decedent's Education (Speci                   | rced If Yes, Give Year<br>or Dates:<br>fv only highest grade com | pleted)     | 1<br>16a. Oecede                 | -            |                      |               | of work done                 | Specify:<br>16b. Kind of Bu         | White<br>siness/Indust  |  |  |  |
| 72 hou<br>n "nat<br>al Exa   | etec             | Elementary/Secondary (0-12)  | College (1-4 or 5  |             | during n                         | nost of wor  | king life. D         | O NOT use r   | etired)                      |                                     |                         | Ĺ  |  |  |
| within ene.  | Completed        | 12   |  |             | Owner/                           | Oper.        |                      |               |                              | Auto Bod                            |                         | Shop   |  |  |
| filed all Hyging of oth  | e Cc             | 17. Father's Name (First, Middle, L                                | ·  |             |                                  |              | 18                   |               |                              | e, Maiden Surname                   | )                       |  |  |  |
| uld be<br>Menta<br>mark<br>c even  | lo B             | Stephen Maxso 19a. Informant's Name/Relationshi                    | Π<br>p (Type, Print )  |             | 19b. Mailin                      | ng Address   | (Street a            |               | F. Gate:<br>or Rural Route N | S<br>umber, City or Tow             | n, State, Zip           | Code)  |  |  |
| 12 sho<br>th and<br>27 is<br>umati   | -                | Cheryl Ann Came  | eron / Frien   | d           | 45580                            | Drayde       | en Roa               | d, Valle      | ey Lee, Ma                   | aryland 206                         | 92                      |  |  |  |
| f Heal<br>friter<br>er tra   |                  | 20a. Method of Disposition  1 Burial 2 X Cremation                 | 3 Removal from Sta   |             | Place of Oispo<br>crematory or o |              |                      |               | Date<br>pril                 | 20c. Location                       | - City or Towr          | n, State                                     |  |  |
| Page:<br>nent o<br>aurt:<br>or oth   |                  | 4 Donation 5 Other Spe   | cifv:  |             | ropolita                         |              |                      | 2             | , 2008                       | Alexand                             |                         |  |  |  |
| Depart<br>Mport<br>njury   |                  | 21 Signature of Funeral Service L                                  | 4 // "   |             |                                  |              |                      |               |                              | Gardiner F                          |                         | lone, P.A.                                   |  |  |
| `ıysician  |                  | 23a. Part I. Enter the disease, or o                               | fardine bmplications that caused                                 | the death   |                                  |              | -                    |               |                              | ryland 2065<br>arrest, shock, or he |                         | proximate Interval                           |  |  |
| Medical  | 1                | failure. List only one cause of<br>Immediate Cause (Final disease  | n each line.<br>a. Intraoral Shotgu                              |             |                                  |              | , 0.                 |               |                              |                                     |                         | etween Onset and<br>Death                    |  |  |
| xaminer  |                  | or condition resulting in death)                                   | Due to (or as a conse  |             |                                  |              |                      |               |                              |                                     |                         | _  |  |  |
|  | <u>.</u>         | Sequentially list conditions, if any, leading to immediate         | b  | auence o    | f):                              |              |                      |               |                              |                                     | -                       |  |  |  |
|  | mine             | cause. Enter Underlying Cause<br>(Oisease or injury that initiated | c  |             |                                  |              |                      |               |                              |                                     |                         |  |  |  |
| led<br>nsit  | Examiner         | events resulting in death) Last                                    | Due to (or as a conse  | equence o   | f).                              |              |                      |               |                              |                                     |                         |  |  |  |
| be executed<br>ician and<br>arial - transit  | dical            | UNPENDED   | d  |             |                                  |              |                      |               |                              |                                     |                         | <u>.                                    </u> |  |  |
| certificate be ending physicia   | Med              | IF FEMALE:   | 23c. If yes, outcon  | ne of preg  | nancy                            |              |                      |               |                              | 23d. Oate o                         | f delivery              | · · ·  |  |  |
| ital or Attending Physician: The law requires that the death certificate be restler death.  Is after death.  In privator: After this certificate has been signed by the attending physited in by the funeral director, page 2 should be detached for use as the bu                               | sician/Me        | 23b. Was decedent pregnant in the past 12 months?                  | 1 Live birth Pregnant at   | time of de  | noth =                           | etal death   | 3                    | Ectopic pre   | gnancy                       | Month                               | Day                     | Year   |  |  |
| death<br>he atte<br>d for u  | ysic             | 1 Yes 2 No 9 Unkr  | 7  |             | 5 C                              | other (Spe   | cify)                |               |                              |                                     |                         |  |  |  |
| hat the<br>ed by the<br>etache   | by Phy           | Part II. Other significant condition                               | ons contributing to death  | but not r   | esulting in the                  | underlying   | cause giv            | en in Part I. |                              | d tobacco use cont                  |                         |  |  |  |
| The law requires that the death cate has been signed by the atte page 2 should be detached for u   | ed b             |  |  |             |                                  |              |                      |               | _                            | Yes 2 ✔ No 3                        |                         | h.command                                    |  |  |
| hysician: The law requiithis certificate has been a director, page 2 should  | ompleted         |  |  |             |                                  |              |                      |               |                              | topsy                               | prior to comp           | y findings available<br>letion of cause of   |  |  |
| The licate h   | S                |  |  |             |                                  |              |                      |               | 1 ✔ Ye                       | rformed?<br>s 2 No '                | death?                  | 2 No   |  |  |
| ician:<br>s certif<br>rector,  | Be               | 25. Was case referred to medical examiner?                         | Hospital: 1 Inpatie  |             | ER/Outpatier                     |              | In.                  | of Death (Che |                              | Desidence 6                         | Oth an Car              |  |  |  |
| To the Hospital or Attending Physician: The lawin 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page  | <u>ا:</u>        | 1 ✓ Yes 2 No<br>27. Manner of Death                                | 28a. Date of Inju  | irv         | 28b. Time of                     |              | XOA C<br>28c. Injury |               | rsing Home 5                 | Residence 6                         |                         | ene  |  |  |
| ath.<br>or: Af   | tion             | 1 Natural 5 Pendi  |  | ear)        | FOUND:<br>1615 hrs               |              | 1 Ye                 | es 2 🗸 No     | Subject s                    | hot self                            |                         |  |  |  |
| or Att<br>fter de<br>Directe<br>in by 1  | ifica            |  | not be Mar 29, 2006  | jury - At h |                                  | eet, factory | , office bui         | ilding, etc.  |                              | n (Street and Numi                  | er or Rural F           | Route Number, City                           |  |  |
| spital<br>nours a<br>neral I   | Certification:   | 4 Homicide determ  | nined (Specify) Sin  | gle Far     | nily                             |              |                      |               | 45580 Dra                    | den Road, Valle                     | y Lee, MD               |  |  |  |
| To the Hos<br>within 24 h<br>To the Fun<br>completely  |                  | (Onoth only  | vsician: To the best of my<br>niner: On the basis of example.    |             | -                                |              |                      |               |                              |                                     |                         | use(s)                                       |  |  |
| To t<br>To t   | Medical          | 29b. Signature and title of certifier                              | and manner stated.   |             |                                  |              | c. License           |               |                              | 29d. Date sig                       |                         |  |  |  |
|  |                  | Tours.   | e of me  | )           |                                  | -0           | O.C.M                |               |                              | March 30,                           |                         |  |  |  |
|  |                  | 30. Name and address of person v                                   |  |             | n 23a)                           |              |                      |               |                              |                                     |                         |  |  |  |
|  |                  | Tasha Greenberg MD.  | Assistant Medica   |             |                                  | 1 Penn S     | Street, B            | altimore,     | MD 21201                     |                                     |                         |  |  |  |
| s  |                  | 31. Date filed (Month, Day, Year)                                  | 32. F gistra   | r's Signati | ure 1                            | and the      |                      |               |                              |                                     |                         |  |  |  |

DHMH 17 Rev 1/2001

OCME ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 23 **Physician** Betty Jane McElroy 2008 10:24 PM March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Sunbridge Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Hours Months Days 1 □ M 2 🗓 F 187-34-8121 81 January 22, 1927 Unknown Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2\\ No Directo Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Price Drive 21921 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Unknown Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 Chesapeake Blvd., Suite 2550, Elkton, MD 21921 Dianne Croom/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 3-25-2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses R.T. Foard Funeral Home, 111 S. Queen St., Rising Maryland 21911 ichara 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alteroschoolic Hear & Discase Immediate Cause (Final disease or condition resulting in death) Unknown Physician /Medical Due to (or as a consequence of) Emprown Examiner neumonia Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed for use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Schizophrenis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No autopsy performed? Yes 2 No has page 2 this certificate To the Hospital or Attending Physiclan; 25. Was case referred to medical examiner? director. 26. Place of Death | Check onl one Medical Certification: To Be Hospital: Other: AM Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature an title of certifier

Jackdens MD

2008 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Sachdev MD 118 North St Fruite 3B, Eleten MD 21921

29c. License number

10023322

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Catharine H. Murphy March 25 2008 3:50 /Medical a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ctr Forest Hill Health and Rehabilitation Forest Hill Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖫 F Director 216-05-4039 Jan 25 1917 MD Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Harford Director MD Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be USA 109 Forest Valley Drive 21050 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify à White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic avent in the second of th Elementary/Secondary (0-12) College (1-4or 5+) Clerical Gunther Brewing Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estelle Goodwin Joseph Spencer Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Johnsen/niece #307 Stamford, Connecticut 06902 123 Harbor Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kriders Church Cemetery 3/28/2008 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Projects of the period of the P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed bunial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the SB attending IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown Day 5 Other (specify) P.O. I the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 page 2 certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 No ۵ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after deau..

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 03223

7373

Registrar

w. Max

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 32. Registrar's Signature

D

|                   |  | ,                | For State   | State of Mary                                   | -                            | ertificate of                              |  | Mental Hy                              | 0.7                          | 0.00                        | I I E O I  |
|-------------------|--|------------------|---|---|------------------------------|--|--|--|------------------------------|-----------------------------|--|
|                   |  | -7               | Registrar  1. Decedent's Name (First, Middle, Las   | <i>t)</i>                                       | - 06                         | intilicate of                              | Death                                    | 2. Date of De                          | Reg. No.                     | 1110                        | 3. Time of Death                                 |
| L,                | Physici  |                  | Griffin Murphy,   | Sr.   |                              |  |  | Month                                  | 16, 200                      | Year                        | 5:40P M  |
|                   | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give   |   |                              | 4b. City, Town, o                          | or Location of Deat                      |  |                              | nty of Death                |  |
|                   |  | \$               | Holy Cross Hosp   |   |                              | Silver                                     |  |  |                              | tgomen                      | у  |
|                   | Funeral  |                  | 5. Social Security Number 6. S  | EN OFF  | n yrs. last birthday<br>Yrs. | Months Days                                | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Bir<br>(Month, Da<br>Apr. 1 | rth                          | 9. Birth<br>Cou             | place (State or Foreign<br>ntry)                 |
|                   | Director   |                  | 239-42-0004 Usual Residence of Decedent   | 7.  | 5 118.                       |  |  | Apr. 1                                 | ,1932                        | NC                          | -  |
|                   | /land<br>ow<br>at  |                  | 10a. State 10b. County  | 10  | c. City, Town or L           | ocation                                    |  |  |                              |                             | 10d. Inside City Limits                          |
|                   | Many<br>a-f sh<br>fied   | 호                | DC  | 1   | Washingt                     | on   |  |  |                              |                             | 1⊠Yes 2□No                                       |
|                   | th the<br>or 28a<br>e not  | )irec            | 10e. Street and Number  |   |                              | 10f. Zip Code                              |  |  | 10g. Citizen o               | of What Cou                 | ntry?  |
|                   | 23a (23a ust b   | Funeral Director | 1528 25th St. SE  |   |                              | 2  | 0020                                     |  | U.S.A                        | •                           |  |
|                   | r des<br>tems  | nue              | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?          | r in U.S. 13                 | . Was Decedent of H<br>If Yes, specify Cub | Hispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No<br>to Rican, etc.)   | D- 14. FI                    | lace - Ameri<br>lack, White |  |
| 36                | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>dieal Examiner must be notified at   | by F             | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ⊠Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: |                              | 1 ☐ Yes 2 ☑ No                             | Specify:                                 |  | Spe                          | city: B                     | lack   |
| 21215-0036        | thour<br>attural   |                  | 15. Decedent's Ed   |   | 16a. Dec                     | edent's Usual Occup                        | oation                                   |  | 16b. Kind of                 | Business/Ir                 | ndustry  |
| 715               | nin 72<br>In "na<br>Medii  | Completed        | (Specify only highest gra   | de completed) College (1-4or 5+)                | (Giv                         | e kind of work done<br>DO NOT use retire   | during most of wo<br>d)                  | rking                                  |                              |                             | ·  |
| 21                | d with   | ĕ                | 12  | Conege (1 401 57)                               | Tour                         | Bus Serv                                   | ice                                      |  | Trans                        | porta                       | tion   |
| pq                | be file<br>tal Hy<br>d othe  | Be (             | 17. Father's Name (First, Middle, Last)   |   |                              |  |  | me (First, Midale                      | e, Maiden Surn               | ame)                        |  |
| yla               | ould hard  | ပ္               | Booker T. Murphy  |   |                              |  |  | Monroe                                 |                              |                             |  |
| Maryland          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                  | 19a. Informant's Name/Relationship ( Rosslyn Stancil/   | • •   | I                            | ling Address (Street<br>Clark Pl           |  |  |                              |                             | p Code)  |
| e,                | 1 and<br>Healt<br>em 2   |                  | 20a. Method of Disposition  |   | 1                            | position (Name of ematory or other pla     |  | Date                                   | 20c. Locatio                 |                             | own, State                                       |
| Baltimore,        | ages<br>ent of<br>it: If it  |                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ | Removal from State                              |                              | ematory or other pla<br>coln Cem.          |  | 22-2008                                | Brentv                       |                             |  |
| i i               | mit. F   |                  | 21. Signature of Funeral Service Licer  | <u>-</u>  |                              | 22. Name and Addre                         |  | t. Linc                                |                              |                             | 110  |
| ä                 | Der<br>Imp   |                  | I show a  | · Coffeele                                      | 4                            | 3401 Blade                                 |  |  |                              |                             | 0722   |
| b                 | 0.00   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | olications that caused the                      | death. Do not er             | nter the mode of dyi                       | ng, such as cardia                       | c or respiratory a                     | arrest,                      |                             | Approximate<br>Interval Between                  |
|                   | Physician  |                  | Immediate Cause (Final disease or condition   | Prostate  |                              |  |  |  |                              | - 1                         | Onset and Death Years                            |
|                   | /Medical   |                  | resulting in death)   | Due to (or as a co                              | nsequence of):               |  |  |  |                              |                             |  |
| 1                 | Examiner   | _                | Sequentially list conditions,   | b. Sepsis                                       |                              |  |  |  |                              |                             | Days   |
|                   | pe isit  | nine             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a co                              | 2                            |  |  |  |                              |                             | II a   |
|                   | xecul<br>and<br>al-trar  | Examine          | that initiated events<br>resulting in death) Last   | c. Renal fai  Due to (or as a co                |                              | <del>-</del>                               |  |  |                              |                             | Hours  |
| 68760,            | icate be executed<br>physician and<br>s the burial-transit   | edical E         |   | Д   |                              |  |  |  |                              |                             |  |
|                   |  |                  |   |   |                              |  |  |  |                              |                             |  |
| Вох               | death certific<br>e attending p<br>d for use as t  | N/UE             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf p<br>1 ☐ Live birth 2 ☐ |                              | □Ectopic pregnanc                          | v  |  |                              | Date of deliv               | •  |
| O. B.             | e dear<br>he att   | Physician/M      | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnant at time<br>9□Unknown                 |                              | Other (specify)                            | ,  |  |                              | Month                       | Day Year   |
| P.O.              | nat the<br>d by the<br>etache  | Phy              | 9 ☐ Unknown  Part II. Other significant conditions of   |   | at reculting in the          | undorlying course giv                      | on in Part I                             | 220 Did                                | tohacco uso o                | ontributo to                | the cause of death?                              |
| Records,          | law requires that the deas been signed by the and should be detached   | by               | Tartii. Other algimicant conditions   | ontributing to death but he                     | or resulting in the          | underlying cause gr                        | verilli alti.                            |  |                              |                             | babiy 4½ Unknown                                 |
| Sor               | v requ<br>been<br>should   | etec             |   |   |                              |  |  |  |                              |                             |  |
| Re                | ne la<br>has<br>je 2   | Completed        |   |   |                              |  |  | 24a. Was<br>auto<br>perf               |                              | prior to co<br>death?       | opsy findings available<br>ompletion of cause of |
|                   | lcian: Th  |                  | 25. Was case referred to medical  |   |                              |  | 26 Place of Do                           | 1□ Yes<br>ath (Check only              | 2 <b>X</b> No                | 1 □ Yes                     | 2□ No  |
| >                 | di S   | To Be            | examiner?<br>1 ☐ Yes 2 ☒ No   | Hospital: 1 🔀 Inpatient                         | 2 ER/Outpatie                | ent 3 DOA Oth                              | or.                                      | dome 5 ☐ Res                           |                              | Other (Spec                 | ifu)   |
| 0                 |  |                  | 27. Manner of Death 1   ↑ Natural 5   ☐ Pending   | 28a. Date of Injury<br>(Month, Day Ye           | 28b. Time<br>lnjury          |  |  | 28d. Describe                          |                              |                             |  |
| Sio               | Attending r death. ector: Afte by the fune   | atio             | 2 ☐ Accident investigation  |   |                              |  | Yes 2 □ No                               |  |                              |                             |  |
| Division or Vital | or Att<br>ter de<br>lirect   | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of injury -<br>building, etc. (S     | At home, farm, s<br>Specify) | treet, factory, office                     |  | 28f. Location (<br>City or To          | (Street and Nu<br>wn, State) | mber or Rui                 | ral Route Number,                                |
|                   | To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu  |                  | 29a. Certifier 1 ☑ Certifying Ph  | ysician: To the best of m                       | w knowledge de               | ath occurred at the #                      | ime date and also                        | a and due to the                       | 001100(2) 25 1               | manner                      | etatod   |
|                   | Hos<br>24 hc<br>Fun<br>etely   | Medical          |   | niner: On the basis of exa<br>and manner stated | amination and/or             | investigation, in my                       | opinion, death occ                       | urred at the time                      | , date and plac              | ce, and due                 | to the cause(s)                                  |
|                   | To the<br>Within<br>To the   | Me               | 29b. Signature and tive of certifier  |   |                              | 29c. Licens                                | se number                                |  | 29d. Date sig                | ned (Month                  | , Day, Year)                                     |
|                   |  |                  | MM/us   | 21  |                              | D00  | 61887                                    |  | March                        | 17. 3                       | 2008   |
| 0                 | (4)  |                  | 30. Name and address of person who  | •   |                              | e, Print)                                  |  | l                                      |                              | , .                         |  |
|                   |  |                  |   | 500 Forest (                                    |                              | , Silver                                   | Spring, N                                | 1D 20902                               |                              |                             |  |
|                   | Sta<br>Registr   | _                | 31. Date filed (Month, Day, Year)  MAR 2 1 2008   | 32. Registrar's                                 | Signature                    |  |  |  |                              |                             |  |
|                   | 3  |                  | MILLIA TO T PARA  | Market of the                                   | 4                            |  |  |  |                              |                             |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 11:20 A MARCH 17, 2008 SHIRLEY MINTO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Yrs. 62 NORTH CAROLINA 02/09/1946 Director 245-72-4927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-1 show mit: If item 27 is marked other than "natural", or litems 23a or 28a-1 show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location MD PRINCE GEORGES LANDOVER 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2202 CONNECTICUT AVENUE 20785 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X N**Vo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH NURSING ASSISTANT PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEWIS EASON PAULINE MOBEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2202 CONNECTICUT AVE. LANDOVER, MD 20785 ALRICK MINTO/HUSBAND Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/22/2008 DUNN, NORTH CAROLINA REST HAVEN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseashock, or heart failure Immediate Cause (Final Physician Sepsis UnKnown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner gangrun of UnKnows Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes Who
9 Unknown for Month Day Year 5 ☐ Other (specify) ed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1∐ Yes 2X No 1 TYes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 Inpatient ij ۴ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Certification: or Attending (Month, Day Year) 1 🗖 Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 24 hours 29a. Certifier i 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) State MAR 2 1 2008 Registrar

29b. Signature and title of certifier

put Pl



M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D43446

Are suit 3-41 Silver spring

29d. Date signed (Month, Day, Year)

3.17.08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:40 PM 03 15 2008 Perkins Melvin Della /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Wheaton Wheaton 1 Year | If Under 24 Hrs. Montgomery If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F Days Hours Min. Director 578-18-4882 88 08/19/1919 VA Louisa, Usual Residence of Decedent 10b. County 10c. City, Town or Location fshow 10d. Inside City Limits "natural", or items 23a or 28a-f show 1X Yes 2 No Directo Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11901 Georgia Avenue 20902 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No þ 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Government Services Inc permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Rice Perkins Addie Mae Crawford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishop W. Melvin, III/Son 400 River Bend Road Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Cemetery 03/21/2008 | Laurel, MD 22. Name and Address of Facility Montgomery-Cheatham Funeral Svcs 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rockville, MD 20850 Immediate Cause (Final disease or condition resulting in death) Physician Pneumoria /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dementia Due to (or as a consequence of): Examine the death certificate be executed physician and s the burial-trans HTW Due to (or as a consequence of): Box 68760 Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Division or Vital 1 Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 1 Tes 2 No 1 Inpatient ٥ 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Daphna Henkin, 18121 Georgia Avenue #103 Olney, MD MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D0053528

29d. Date signed (Month, Day, Year)

March 19, 2008

20832

State Registrar

31. Date filed (Month, Day, Year)



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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

DIL

2:80 PM

MARSHALL,

P.O. Box 68760 Division or Vital Records,

To the Hospital

within 24 hours after death.

To the Funeral Director: /

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier P. V. Nangar N

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

smeet

D0065733

suti

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

3B. ECKTON, MD-21921

03/25/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYANA RAS V. PULA 118 NORTH

31. Date filed (Month, Day, Year)

MAR 2 7 2008



|                    |   |                | State of Maryla  | -                            | artment of H                                  |   |   |   |  |
|--------------------|---|----------------|--|------------------------------|---|---|---|---|--|
| li a               |   |                | Registrar  1. Decedent's Name (First, Middle, Last)  | Cer                          | Tillicate of I                                | Jean  | 2. Date of Deat                         | eg. No.2 0 0 8                                | 3 Time of Death                                      |
|                    | Physici   |                |  |                              |   |   | Month                                   | Day Year                                      | 1.6  |
|                    | /Medic<br>Examin  |                | Anna Maiorano Piatelli  4a. Facility Name (If not institution, give street and number)   |                              | 4b. City, Town, or                            | r Location of Death                           | March                                   | 22 2008<br>4c. County of Dea                  |  |
|                    |   |                | Union Hospital of Cecil Coun   | tv                           | E1kto   | n   |   | Cecil   |  |
|                    | Funeral   |                |  | rs. last birthday)           | If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min.                | 8. Date of Birth<br>(Month, Day,        | Year) 9. Bi                                   | rthplace (State or Foreign                           |
|                    | Director  |                | 218-40-0192 97   | Yrs.                         |   |   | June 4,                                 |   | nnsylvania   |
|                    | land<br>t   |                | Usual Residence of Decedent  10a. State 10b. County 10c.   | City, Town or Lo             | ocation                                       |   |   |   | 10d. Inside City Limits                              |
|                    | Mary<br>-f sh<br>fied a   | to             | Maryland Cecil   | E1kton                       |   |   |   |   | 1 X Yes 2 □ No                                       |
|                    | h the   | Director       | 10e. Street and Number   |                              | 10f. Zip Code                                 |   | 10                                      | 0g. Citizen of What C                         | country?   |
|                    | th wit  |                | 1 Colonial Court   |                              | 21921   |   |   | United St                                     | ates   |
|                    | r dea   | Funeral        | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | U.S. 13.                     | Was Decedent of H                             | lispanic Origin? (Spe<br>an, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.)        | 14. Race - Am<br>Black, Wh                    |  |
| 36                 | s afte  | by F           | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   |                              | 1 ☐ Yes 2 🙀 No                                | Specify:                                      |   | Specify: W                                    |  |
| 8                  | hour ttural   | ed to          | 3 bd Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education   | 16a, Decer                   | dent's Usual Occup                            | ation   | _                                       | 16b. Kind of Busines                          |  |
| 75                 | nin 72<br>In "na<br>Medi  | plet           | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   | (Give                        | kind of work done of DO NOT use retired       | during most of worki                          | ng                                      |   | , mada y   |
| 21215-0036         | d with<br>giene<br>er tha   | Completed      | 5  | Home                         | emaker  |   |   | Own Ho  | me   |
| Maryland           | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at   | Be             | 17. Father's Name ( <i>First, Middle, Last</i> ) <b>Giovanno Maiorano</b>  |                              |   | 18. Mother's Name Antonie                     | (First, Middle, N<br>tta Iovi           | ,   |  |
| 2                  | 2 should<br>and Me<br>is mark<br>aumatid  | 욘              | 19a. Informant's Name/Relationship (Type. Print)   | 19b. Mailir                  | ng Address (Street                            | and Number or Rura                            | al Route Number                         | City or Town, State,                          | Zio Code)  |
|                    | Health ar<br>Health ar<br>tem 27 is   |                | Patricia Carroll / Granddaugh  |                              |   |   |   |   |  |
| altimore,          | es 1 a of He of He if item  |                |  | o. Place of Dispo            | sition (Name of<br>matory or other place      | e). Marc                                      | ate :                                   | 20c. Location - City o                        | r Town, State  |
| <u>ĕ</u>           | permit. Pages Department of I Important: If ite any Injury or or once.  |                | 4 Donation 5 Done (Specify)  | Cemet                        |   | 28,   | 2008   E                                | Elkton, Ma                                    |  |
| Balt               | ermit.<br>epart<br>nport<br>ny Inj<br>nce.  |                | 21. Signature of Fundal Service Licensee   | I .                          |   |   |   | neral Home                                    |  |
|                    | 90 E 8 9  |                | VIIIOUEC   |                              |   |   |   |   | aryland21901   |
|                    |   |                | 23a. Part1. Enter the disease, or a lications that caused the dishock, or heart failure. List only of ause on each line.                         | eath. Do not ent             | er the mode of dyin                           | g, such as cardiac o                          | or respiratory arre                     | est,  | Approximate<br>Interval Between<br>Onset and Death   |
|                    | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  |                              | NFALCTIO                                      | <b>W</b>                                      |   |   | Hours  |
| 8                  | Examiner  |                | Due to (or as a cons   |                              | PARCTION                                      | (   |   |   | Hours  |
| - %                | - Or Market   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                      |                              | 1141-01 101                                   | ,   |   |   | Pro-ocy  |
|                    | acuted<br>nd<br>transi  | Examiner       | that initiated events  |                              | TION  |   |   |   | PAYS   |
| 8760,              | The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit   | Ē              | Due to (or as a cons   | equence of):                 |   |   |   |   |  |
| 387                | physicate by the b  | dical          | d  |                              |   |   |   |   |  |
| ×                  | eath certific<br>attending p<br>for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pre  |                              |   |   |   | 23d. Date of de                               | elivery  |
| . Box              | death<br>e atte   | icia           | in the past 12 months?   |                              | Ectopic pregnancy Other (specify)             |   |   | Month   | Day Year   |
| Ö                  | that the de<br>ned by the a<br>detached t   | hys            | 9 ☐ Unknown  |                              | -   |   | _                                       |   |  |
| Vital Records, P.O | w requires that been signed I should be det   | by F           | Part II. Other significant conditions contributing to death but not  | esulting in the ur           | nderlying cause give                          | en in Part I.                                 |   |   | to the cause of death?                               |
| ord                | requir<br>een s<br>rould  | ted            |  |                              |   |   | 1 □ Ye                                  | es 2 <b>□</b> √No 3 □ F                       | Probably 4 □Unknown                                  |
| Sec.               | has b   | Completed      |  |                              |   |   | 24a. Was ar<br>autops                   | y prior to                                    | autopsy findings available<br>completion of cause of |
| a                  |   |                |  |                              |   |   | perform<br>1□ Yes 2                     | ned? death?<br>2 ☑ No 1 ☐ Ye                  | s 2 10   |
| <u> </u>           | nyslcian:<br>nis certifica<br>director, I   | Be             | 25. Was case referred to medical examiner?  Hospital:  |                              | ot all DOA Othe                               | 26. Place of Death                            |   |   |  |
| ō                  | Physer this eral di   | To             | 27. Manper of Death 28a. Date of Injury  | ER/Outpatien<br>28b. Time of | IL SELDOA                                     | 4 LI Nursing Hor                              |   | nce 6 Other (Sp                               | ecify)   |
| ion                | nding F<br>tth.<br>r: After i<br>e funera   | ţi             | 1 ☑ Natural 5 ☐ Pending (Month, Day Year<br>2 ☐ Accident investigation   | ) Injury                     |   | k?<br>Yes 2 □ No                              |   | , ,   |  |
| Division or        | r Attender death rector:  | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - A building, etc. (Spe  | home, farm, str              | eet, factory, office                          | 2   | 28f. Location (Str<br>City or Town      | reet and Number or F                          | Rural Route Number,                                  |
|                    | pital or<br>ours afte<br>leral Di<br>filled in  | Cer            |  |                              |   | 1   |   |   | 19   |
|                    | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification that the funeral director, to ompletely filled in by the funeral director, to the funeral director, the funeral director, the funeral director is the funeral director. | Medical        | 29a. Certifier 1 ☐ Certifying Physician: To the best of my length (Check only one) 1 ☐ Medical Examiner: On the basis of exam and manner stated. | ination and/or in            | h occurred at the tin<br>vestigation, in my o | ne, date and place, a<br>pinion, death occurr | and due to the ca<br>red at the time, d | ause(s) and manner a<br>ate and place, and du | as stated.<br>ue to the cause(s)                     |
|                    | To the Hos<br>within 24 ho<br>To the Fun<br>completely  | Me             | 29b. Signature and title of certifier  |                              | 29c. License                                  | e number                                      | 25                                      | 9d. Date signed (Mor                          | oth, Day, Year)                                      |
|                    |   |                | & MD   |                              | D004  | וודר  |   | MARCH d                                       | 5,2008   |
|                    | 10  |                | 30. Name and address of person who completed cause of death (I   | tem 23a) (Type,              | Print)  | <u> </u>                                      |   |   |  |
|                    | ١   |                | DAVID GAR-EL 304-306 Was   | th Stra                      | et Suite                                      | =3 EL+  | TOW MA                                  | HRYLIND                                       | 21921  |
|                    | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  MAR 2 6 2008  32. Registrar's Signary   | , K                          | god   |   |   |   |  |

|              |  |                | _ roi  | partment of Health and Nertificate of Death   | Reg. No.   | onno llene   |
|--------------|--|----------------|--|---|--|--|
|              | Physici  | an             | Decedent's Name (First, Middle, Last)  |   | 2. Date of Death<br>Month Day                          | 3. Time of Death   |
| 8            | /Medi  |                | Lucille E. Richardson  |   | 03/23/08   |  |
|              | Examir   | ier            | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |  | County of Death  |
|              | <b>等人,别</b>  | 3.4            | Prince George Hospital   | Cheverly  If Under 1 Year   If Under 24 Hrs.  |  | rince George   |
|              | <ul> <li>Funeral</li> <li>Director</li> </ul>  |                | 5. Social Security Number 578-54-6858  Usual Residence of Decedent  6. Sex 1 M X F 7. Age (In yrs. last birthde  | Months Days Hours Min.  | 8. Date of Birth (Month, Day, Year) 04/01/4(           |  |
|              | Maryland<br>e-f ehow   | ctor           | Md Prince George Lando   |   |  | 10d. Inside City Limit   |
|              | th with the<br>23a or 28   | ai Director    | 3211 75th Ave #101   | 10f. Zip Code<br>20785  |  | izen of What Country?<br>JSA   |
| 036          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28e-f ehow myortant: If Item 27 is marked other than "natural; or Itema 23a or 28e-f ehow myoring or other treumatic event, the Madical Examinar must be nutilised at ance.  | by Funeral     | 1 Never Married 2 Married 1 Yes 2 No   | <ol> <li>Was Decedent of Hispanic Origin? (Sf<br/>If Yes, specify Cuban, Mexican, Puerto<br/>1 ☐ Yes 2 (XNo Specify:</li> </ol> | pecify Yes or No-<br>p Rican, etc.)                    | 14. Race - American Indian, Black, White, etc.  Specify: Black                           |
| 21215-0036   | within 72 ho<br>ene.<br>than "natui<br>ha Medical  | Completed      | (Specify only highest grade completed) (Gi   | cedent's Usual Occupation we kind of work done during most of work by DO NOT use retired) Curity                                | king   | ind of Business/Industry   |
| Maryland 2   | 12 should be filed within 7<br>h and Mental Hygiene.<br>7 Is marked other than "<br>treumatic event, the Mad   | To Be C        | 17. Father's Name (First, Middle, Last)  Mack Scott  |   | ne (First, Middle, Maiden<br>e Farley                  | Sumame)  |
| lan          | 2 sho<br>and<br>ls ma  |                |  | illing Address (Street and Number or Ru   | -  |  |
| Baltimore, N | Pages 1 and 2<br>nent of Health<br>int: If Item 27<br>Iry or other tre   |                | 20a. Method of Disposition 20b. Place of Discemetery, commentary,  | 1 75th Ave #101  position (Name of rematory or other place)  lale Crematory 3   | Date 20c. Lo   | ocation - City or Town, State  |
| Baltii       | permit. Page<br>Department of<br>Important: If<br>eny injury or<br>once.   |                | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility Sr<br>1409 Fairlakes   | ead Mortu<br>Pl Ste B                                  | ary Service, P. Mitchellville,   |
|              | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  The first caused the death. Do not de |   | or respiratory arrest,                                 | Approximate Interval Between Onset and Death 2 years                                     |
| 68760,       | death certificate be executed  a eattending physicien and  defor use as the burial-transit  a  | ical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Congestive Head Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  | art Failure   |  | 5 years  |
| Box          | death certific<br>e attending p<br>d for use as  | Physician/Medi |  | 3□Ectopic pregnancy<br>5□ Other (specify)   |  | 23d. Date of delivery<br>Month Day Year  |
| rds, P       | quires that the dei<br>n signed by the a<br>uld be detached f  | by             | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   | 23e. Did tobacco u                                     | use contribute to the cause of death?  XNo 3 Probably 4 Unknow                           |
| al Records,  | ysician: The law requires that the is certificate has been signed by th director, page 2 should be detached.   | Completed      |  |   | 24a. Was an<br>autopsy<br>performed?<br>1 ☐ Yes 2 ☐ No | 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No |
| Vital        | Physician:<br>this certificatal director, p  | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Manpatient 2 ☐ ER/Outpat  | Other   | th (Check only one)                                    | 0 Floring (0(1)  |
| o            | ng Ph<br>fter th<br>ineral   | ation; To      | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation   | of 28c. Injury at   | ome 5 Residence<br>28d. Describe how injur             |  |
| Division     | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)   | street, factory, office   | 28f. Location (Street an<br>City or Town, State        | nd Number or Rural Route Number,<br>a)   |
|              | To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Director Completely filled in the Funeral Completely filled | ea             | 29a Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de control of the desired form of the desir | increasingsing in marchine death again  |  | d = 1 = d = d = (-)  |
| )            | of with  | 2              | 29b. Signature and title of certifier  30. Name and address of person who empleted cause of death (ftern 23a) (Type FAR HAD JAMALIM 7525  31. Date filed (Month, Day, Year)  MAR 2 6 2008  32. Registrar's Signature   | 29c. License number 200582  | 13 3/  | te signed (Month, Day, Year)   |
|              | V  |                | 30. Name and address of person who empleted cause of death (ftem 23a) (Typer FAR HAD JAMALIM 7525 C  | Preeuncy Ctr Dr   | Greente  | H MD 20770   |
|              | Sta<br>Regist  | ate<br>rar     | MAR 2 6 2008   | bete  |  |  |

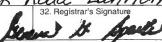
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** OUISE KOGERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea Examiner DOCTORS HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. GEORGES 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 577 34 4177 WASH Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No PRINCE GEORGES Director MD KIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S. 6314 2073 23a ARTERS Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TV No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) COURT HOUSE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM CHRISTIAN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ARY FRANKLIN /D WASH DE 20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State KINERDALE MIC 21. Signature of Funeral Service Lidens JOHN I PHINES FUNERALHUME celle Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancel Due to (or as a onsequence of) /Medical Examiner My o cerde as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Hy and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ cate has been sig page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 2□ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral filled in by the funeral 27. Manner of Death 1 W Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of C 29d. Date signed (Month, Day, Year)

(R 6)

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 1 2008

Name and address



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** SUDA, JR. 05:33 PM WILLIAM 23 MARCH 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 ☐ F 53 Director 221-44-3238 FEB. 4, 1955 DELAWARE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ms 23a or 28a-f show **NEWARK** 1 ☐ Yes 2 No Director DELAWARE NEW CASTLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 TOP VIEW CT. 19702 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or items, 11. Marital Status Black, White, etc. Armed Forces.

1 X Yes 2 □ No.

1 Yes, Give 1973.

Year or Dates:1977 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify ģ Specify: 3 ☐ Widowed 4 X Divorced WHITE "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BRICKLAYER UNION/CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ WILLIAM J. SUDA, SR. MARIE G. MCNATT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health Important: If item 27 any Injury or other tr once. DORIS M. CRAIN / SISTER 142 WEDGEFIELD DR., NEW CASTLE, DE 19720 20b. Place of Disposition (Name of Cemetery, crematory or other place)
DELAWARE VETERANS
MEMORIAL CEMETERY Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 03/31/2008 BEAR, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License SPICER-MULLIKIN FUNERAL HOMES, INC. M00840 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ENP- STAGE LUNG FIBROSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE RESPIRATORY Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ettending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? es 2XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation Injury 1 Yes 2 🗌 No after death.

Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a myre my. AMETOR KE(-000 MAKCH, 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4.4 VA BALTIMURE MARYLAND OMER NATIR 31. Date filed (Month, Day, Year) State 2008 MAR 2 7 Registrar

|   |  |                | for State Registrar  | State o                            | f Mary                            |                       |            | ment of H                               |                           | and M                    |   | giene<br>Reg. No. |                           | 8              | 11603                                      |
|---|--|----------------|--|------------------------------------|-----------------------------------|-----------------------|------------|---|---------------------------|--------------------------|---|-------------------|---------------------------|----------------|--|
|   | Physici  | an             | Decedent's Name (First, Middle, La   | . ,                                |                                   |                       |            |   | ·                         |                          | Date of Dea     Month                   | Day<br>24         | Yea                       |                | 3. Time of Death                           |
|   | /Medic   | cal            | 4a. Facility Name (If not institution, gi  | Somaz                              |                                   |                       | 41         | o. City, Town, or                       | Location                  |                          | March                                   |                   | 2008<br>County of De      |                | 4:20 P M                                   |
|   | Examin   | ier            | Stella Maris Hos   |                                    | inber)                            |                       | 7          | Timoni                                  |                           | n Death                  |   |                   | Balti                     |                | e  |
|   | Funeral  |                | Social Security Number 6.  | Sex                                | 7. Age (Ir                        | yrs. last birth       |            | Under 1 Year<br>onths Days              | If Under                  | 24 Hrs.                  | 8. Date of Birt                         | l                 |                           |                | ce (State or Foreign                       |
|   | Director   |                | 232 24 2164  | MM 2□F                             | 86                                | Y                     | rs.        | Olitis Days                             | riouis                    | 191111.                  | 8. Date of Birt<br>(Month, Da<br>Nov 22 | 2, 19             | 21                        | WV             |  |
| and   | A 11   |                | Usual Residence of Decedent  10a. State 10b. County  |                                    | 10                                | c. City, Town         | or Locati  | on                                      |                           |                          |   |                   |                           | 10d            | I. Inside City Limits                      |
| Mary  | a-f sh   | ţċ             | MD Baltimo   | re                                 |                                   | Catons                | svill      | .e                                      |                           |                          |   |                   |                           |                | 1 ∐Yes 2 <b>X</b> No                       |
| th the  | or 28  | Director       | 10e. Street and Number   |                                    |                                   |                       | 1          | 0f. Zip Code                            |                           |                          |   | 10g. Citize       | en of What                | Country        | /?   |
| G Z I Z I 3-0030<br>filed within 72 hours after death with the Marvland | ral", or items 23a or 28a-f show<br>Exantinet inust be notified at   | ral            | 719 Maiden Choic   | e Lane                             | Apt                               | BR-318                | 3          | 21228                                   | }                         |                          |   | Uni               | ted S                     | tate           | es   |
| er de   | Items  | Funeral        | 11. Marital Status   | 12. Was Dece<br>Armed Fo           | rces?                             | in U.S.               | 13. Was    | Decedent of Hi<br>s, specify Cuba       | ispanic Ori<br>n, Mexican | gin? (Spe<br>1, Puerto I | cify Yes or No-<br>Rican, etc.)         | 14                | 1. Race - Ar<br>Black, Wh |                |  |
| OOOS aff  | J., or   | by             | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 [⊉Yes<br>If Yes, Gi<br>Year or D | 10                                | known                 | 1 🗆        | Yes 2K∏No                               | Specify:                  |                          |   | s                 | Specify: W                | hite           | 2  |
| 2 Po  | nature<br>lical E  | Completed      | 15. Decedent's E   | ducation                           |                                   | 16a. [                | Decedent   | 's Usual Occupa                         | ation                     |                          |   | 16b. Kind         | of Busines                |                |  |
| Thin 7  | ne.<br>nan "r  | nple           | (Specify only highest gr<br>Elementary/Secondary (0-12)  | College (1                         | -4or 5+)                          | 1                     |            | of work done of<br>NOT use retired      | juring mosi<br>)          | t ot workir              | ng                                      |                   |                           |                |  |
| Z Z   | Hygie<br>ther ti<br>nt, in   |                | 12 17. Father's Name (First, Middle, Last  | 1                                  |                                   |                       | nspe       | ctor                                    | 10 Matha                  | ula Nissas               | (First Middle                           |                   | tille                     | ry             |  |
| 9   | sed of   | Be c           | Charles Pasquale   |                                    | e                                 |                       |            |   |                           |                          | (First, Middle,<br>a Gabri              |                   | ,                         |                |  |
| al yla  | if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a other traumatic event, It a Medical Exx., it activists to | မ              | 19a. Informant's Name/Relationship   |                                    |                                   | 19b. I                | Mailing A  |   |                           |                          |   |                   | -                         | . Zip C        | ode) 21228                                 |
| and 2   | ertra  |                | Betty June Somaz   | ze/Wife                            |                                   | 1                     |            |   |                           |                          |   |                   |                           |                | ille, MD                                   |
| es 1.   | of He  |                | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐  | Domoval from                       | State 2                           |                       |            | n (Name of<br>ery or other place        |                           |                          | ate                                     |                   | ation - City              |                |  |
| r. Pages  | tant: I  |                | 4 Donation 5 Other (Speci  |                                    |                                   |                       |            | Cemete                                  |                           | 3-28-                    | 2008                                    | Elli              | cott (                    | City           | , MD                                       |
| Dall.   | Department of Health a Important: if Item 27 Is any Injury or other trau.  |                | 21. Signature of Funeral Service Lice  | nsee Ale                           | MO                                | 1044                  | 1          | ame and Addres                          |                           | Har                      |   |                   |                           |                | Ly FH Inc.<br>1D 21043                     |
|   |  |                | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only   | plications that c                  | aused the                         | death. Do no          |            |   |                           |                          |   |                   |                           | A A            | pproximate<br>nterval Between              |
| •   | ysician  |                | Immediate Cause (Final disease or condition  | a PANCE                            | REATI                             | C CANC                | ER         |   |                           |                          |   |                   |                           | 0              | Inset and Death                            |
|   | Medical<br>caminer   |                | resulting in death)  |                                    |                                   | nsequence of          |            |   |                           |                          |   |                   |                           |                |  |
|   |  | ē              | Sequentially list conditions, if any, leading to immediate   | b. Due to                          | or as a co                        | nsequence of          | f):        |   |                           |                          |   |                   |                           | $\vdash$       |  |
| cuted   | nd<br>ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Find I hoory in Cause (Disease or injury that initiated events | C                                  |                                   |                       |            |   |                           |                          |   |                   |                           |                |  |
| be exe  | physician and<br>the burial-transit  |                | resulting in death) Last   |                                    | or as a co                        | nsequence of          | f):        | *****                                   |                           |                          |   |                   |                           |                |  |
| The law requires that the death certificate be executed                 | physic<br>the b  | dical          |  | d                                  |                                   |                       |            |   |                           |                          |   |                   |                           |                |  |
| certifi   | attending p<br>for use as  | Physician/Me   | IF FEMALE:   | 23c. If yes, out                   | come of p                         | regnancy              |            |   |                           |                          |   |                   |                           | 1              |  |
| death   | d for u  | ciar           | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No   | 1 Live I                           |                                   | Fetal death           |            | topic pregnancy<br>her <i>(specify)</i> | ,                         |                          |   | 23                | d. Date of o<br>Month     | delivery<br>Da |  |
| t the   | by the   | hys            | 9 Unknown  | 9 ☐ Unkn                           | own                               |                       |            |   |                           |                          |   |                   |                           |                |  |
| es tha  | igne<br>be d   | by P           | Part II. Other significant conditions  | contributing to de                 | eath but no                       | at resulting in t     | the under  | lying cause give                        | en in Part I.             |                          | 23e. Did to                             | bacco use         | e contribute              | to the         | cause of death?                            |
| requir  | s peen s   |                |  |                                    |                                   |                       |            |   |                           |                          | 1 🗆 Y                                   | 'es 2 🗍           | No 3□                     | Probab         | ly 4 Unknown                               |
| e law   | has<br>Je 2  | Completed      |  |                                    |                                   |                       |            |   |                           |                          | 24a. Was a<br>autop                     | sy                | prior t                   | o comp         | y findings available<br>letion of cause of |
| # H   | certificate he<br>ector, page  |                | OF Was appeared to medical   |                                    |                                   |                       |            |   |                           |                          | perfor<br>1 □ Yes                       | 2 💢 No            | death'<br>1 ☐ Ye          |                | □No  |
| ysicia  | r this certific<br>ral director, I   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No   | Hospital: 1 🗆 I                    | nnationt                          | 2 🗌 ER/Outp           | nationt S  | Othe                                    |                           |                          | (Check only or                          |                   | T 0th (0                  |                | HOSPICE                                    |
| Attending Physician:  | th.<br>: After thi<br>: funeral o  |                | 27. Manner of Death  | 28a. Date                          |                                   | 28b. Tir              |            | 28c. Injury<br>Work                     |                           |                          | 8d. Describe h                          |                   |                           | oecity)        | HOSPICE                                    |
| tendi   | eath.  | catic          | 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b  | n                                  | , Day, 10.                        | ,                     |            |   | res 2□N                   | No                       |   |                   |                           |                |  |
| or At   | ours after death. eral Director: A: filled in by the fu  | Certification: | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined   | 28e. Place                         | of Injury -<br>ng, etc. <i>(S</i> | At home, farm pecify) | n, street, | factory, office                         |                           | 2                        | 8f. Location (S<br>City or Tow          |                   | Number or                 | Rural F        | loute Number,                              |
| pital   | eral (   |                | 29a. Certifier 1X Certifying P   | vsician. To the                    | hest of m                         | v knowledge           | doath oc   | ourrod at the tim                       | o data an                 | nd place of              | and due to the                          |                   |                           |                |  |
| e Hos   | within 24 hours after To the Funeral Directory completely filled in by   | ledicai        | (Check only 2 Medical Examone)   | miner: On the b                    | asis of exa                       | mination and/         | or invest  | igation, in my or                       | oinion, dea               | th occurre               | ed at the time,                         | date and p        | lace, and d               | ue to th       | e cause(s)                                 |
| 7o th   | withir<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  |                                    |                                   |                       |            | 29c. License                            |                           |                          |   |                   | signed (Mo                |                |  |
|   | 2+1  |                | 10.  | _                                  |                                   |                       |            | D4.                                     | 372                       | 5                        |   | 31                | 261                       | 08             |  |
|   | E.G.   |                | 30. Name and address of person who   |                                    |                                   | , , , ,               |            | ,                                       |                           |                          |   |                   |                           |                | -  |
|   | Stat   | te             | DR. TARIQ MAHMOO  31. Date filed (Month, Day, Year)  | DD 2300<br>32. ₱                   | <b>DUL</b><br>egistrar's S        | ANEY V                | ALLE       | Y RD.                                   | LIMON                     | IUM,                     | MD 210                                  | 93                |                           |                |  |
|   | Registra   |                | 31. Date filed (Month, Day, Year) MAR 2 7 2  | 008                                | eren                              | B                     | A service  | W                                       |                           |                          |   |                   |                           |                |  |

MARCH 24, 2008 4:20 p.m.

LEO SOMAZZE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** March 28, 2008 3:45 am<sup>M</sup> Virginia Denmead Sweeney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Director 220-09-6497 91 10/06/1916 Maryland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland St. Mary's Tall Timbers 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Examiner must be none. 17726 Grace Lane 20690 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: <u>م</u> Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Deli Owner Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Franklin Kelley Alma Lucille Gemmill ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Sweeney/Step Son 2351 NW 83rd Avenue, Pembroke Pines, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 04/02/2008 Baltimore, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onser and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lake resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseque The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, Three Notch Road, Hollywood, MD 31. Date filed (Month Day, Year) distrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #17 Per F.H. asbl Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2008 1100P M **Physician** Ronald Lee Simmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace 1724 Deths Ford Road 8. Date of Birth (Month, Day, Year) Sept. 12, 1 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Gountry) Maryland **Funeral** Days 1⊠M 2□F 1930 Yrs. 77 219-28-2328 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 2.15 m marked thysichen "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be natified at once. 1 Yes 2 No Director Havre de Grace Maryland Harkord 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21078 1724 Deths Ford Road Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Holcomb Simmons Cou Ford Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1724 Deths Ford Road, Havre de Grace, MD 21078 Jean Simmons (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 OCremation 3 □ Removal from State West Chester, PA R.A. Ferris & Co. 3/31/2008 \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 S. Washington St. Havre de Grace, MD 21078 Approximate Interval Between Onset and Death of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ancreati Pnysician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Month in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown the 9 Unknown 2 Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Type 2 No 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No ihis funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending investigation 1 [XINatural 2 🗆 No 1 Tes death. 2 Accident Director: Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide within 24 hours after d To the Funeral Direct completely filled in by determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Box 68760.

P.O. I

31. Date filed (Month, Day, Year) State Registrar

MAR 3 1 2008

nny

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MP

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 22, Theresa Trinidad 2008 Savoy March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Prince Georges Date of Birth (Month, Day, Year) 06/23/1955 Maryland . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🕇 F Months Days Hours 52 Director 212-66-6261 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 XYes 2 No ms 23a or 28a-f sl Director Maryland Prince Georges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with items 23a 20735 9525 Badger Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 X Never Married 2 ☐ Married P. altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Colony South Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Thelma Herman Savoy Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Blagmon / Sister 12903 Turnberry Circle Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 3/28/08 Clinton, Maryland 21. Sign, ture Jupe 17 en ce Licen 22. Name and Address of Facility Adams Funeral Home PA CH 191 20605 Aquasco Rd. Aquasco, Maryland 20608 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Metasteti /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No 9∏Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performe certificate ha 2**X**No 1□ Yes 2XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ဥ 1 npatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

P.O. Box 68760 Records, Division or Vital the Hospital or Attending Physician: ¹ hours after death. ¹uneral Director: A ely filled in by the fu within 24 hours at To the Funerat C completely filled i

> 179 State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certi

Medical

RAHIMIAM, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

africe all MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10403

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0052999

Hospital Drive Cult

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Anneliese Schlossenberg 24, 12:00 A M March 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Health Services Baltimore Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F 79 Yrs. 212-46-7991 June 13 1928 Director Germany Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Maryland Baltimore Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21207 4868 Carmine Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 NDivorced other then "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manufacturing factory worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itsm 27 is marked oth eny injury or other traumatic event 9028. Sibilla Maria (maiden name unknown) Peter Josef Esser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hampstead, Maryland 21074 2117 Moonlight Drive Peter Schlossenberg - son March 28 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland Carroll Cremation 2008 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License M01072 934 South Main Street Hampstead, Maryland 21074 wares 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) interrosde **Physician** WS. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Gecords, P.O. Box 6 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No 9 Unknown 3 Ectopic pregnancy Year Month Day 4\_Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💥 No 1 Inpatient 2 ER/Outpatient 3 DOA Cert fication: To SIL in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Al within 24 hours after or To the Funaral Direct completely filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 25643 wit ndal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boolto MD n 6565 N. Charles St. Suite 209/ aukner MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 26 2008 Registrar

|                            |   |                | 1 - State<br>Registrar  | State of Maryla                                |                                       | artment of H                               |                                   |  | giene 2008                               | 11608                             |
|----------------------------|---|----------------|---|--|---------------------------------------|--|-----------------------------------|--|--|-----------------------------------|
|                            | ν.  |                | Decedent's Name (First, Middle, Last)   |  |                                       |  |                                   | 2. Date of Dea                               | ath                                      | 3. Time of Death                  |
|                            | Physici<br>/Medic   |                | Samuel Lee Sm   | ith  |                                       |  |                                   | March  | 20, 2008                                 | 03:45 PM                          |
|                            | Examin  | market 1       | 4a. Facility Name (If not institution, give s   |  |                                       | 4b. City, Town, o                          | r Location of D                   | Death  | 4c. County of Death                      |                                   |
|                            |   |                | 103 Washington St   | reet   |                                       | North E                                    |                                   |  | Cecil                                    |                                   |
|                            | Funeral   |                | 5. Social Security Number 6. Sex  | M 00 C   | rrs. last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days             | If Under 24<br>Hours              | Min. (Month, Day                             | v. Year) Cou                             | place (State or Foreign<br>intry) |
|                            | Director  |                | 232-58-1682 PSI Usual Residence of Decedent   | 68   | 115.                                  |  |                                   | March 2                                      | 4,1939 West                              | Virginia                          |
|                            | yland<br>now  |                | 10a. State 10b. County  | 10c.   | City, Town or Lo                      | cation                                     |                                   |  |  | 10d. Inside City Limits           |
|                            | Man,  | ģ              | Maryland Cecil  |  | North Ea                              | ast  |                                   |  |  | 1 X Yes 2 ☐ No                    |
|                            | th the  | Director       | 10e. Street and Number  |  |                                       | 10f. Zip Code                              |                                   |  | 10g. Citizen of What Cou                 | intry?                            |
|                            | 23a   |                | 103 Washington Str  | eet  |                                       | 2190                                       | 1                                 |  | United Stat                              | es                                |
|                            | tems  | Funeral        |   | 2. Was Decedent Ever in<br>Armed Forces?       | n U.S. 13. \                          | Was Decedent of H<br>f Yes, specify Cuba   | lispanic Origin<br>an, Mexican, P | ? (Specify Yes or No-<br>Puerto Rican, etc.) | 14. Race - Amer<br>Black, White          |                                   |
| 36                         | rs afte   | by F           | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:     |                                       | I□Yes 2⅓No                                 | Specify:                          |  | Specify: B                               | lack                              |
| 8                          | within 72 hours after deeth with the Maryland<br>ene.<br>than 'natural', or items 23a or 28e-f ehow<br>than "Madical Examinar must be indiffed at   | ed             | 15. Decedent's Educ   | ation  |                                       | ient's Usual Occup                         |                                   |  | 16b. Kind of Business/li                 | ndustry                           |
| 215                        | hin 72  | Completed      | (Specify only highest grade Elementary/Secondary (0-12)   | completed) College (1-4 or 5+)                 | (Give                                 | kind of work done of<br>DO NOT use retired | during most of<br>d)              | f working                                    |  | •                                 |
| 7                          | od wit  | Š              | 10  |  | Main                                  | ntenance                                   | Mechan                            | ic   | Retail                                   |                                   |
| n                          | be file   | Be             | 17. Father's Name (First, Middle, Last)   |  |                                       |  |                                   | Name (First, Middle,                         |  |                                   |
| yla                        | Men<br>Men<br>Men<br>Men<br>Men<br>Men<br>Men<br>Men<br>Men<br>Men  | ဥ              | Bishop Lawrence   |  |                                       |  |                                   | garet Ande                                   |  |                                   |
| Maryland 21215-0036        | 12 sh<br>h and<br>7 le m<br>traum   |                | 19a. Informant's Name/Relationship (Typ   |  | 1000000                               | 22 %                                       |                                   |  | er, City or Town, State, Zi              |                                   |
| o<br>O                     | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28e-1 show mortent: if item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examination in the indifficial and once. |                | Mary Smith / Spous 20a Method of Disposition  |  | <ul> <li>b. Place of Dispo</li> </ul> | sition (Name of                            | 3.6                               | et, North_<br>arch                           | East, Maryl<br>20c. Location - City or T | and 21901<br>own, State           |
| 100                        | ages<br>ant of<br>it: If it<br>y or c   | 4              | 1 🛣 Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)   | moval from State                               |                                       | natory or other place<br>st Method         | .,                                |  | North East,                              |                                   |
| Baltimore,                 | nit. Pertme   | 1              | 21. Signatur Funer Liservice Ligense  |  |                                       |  |                                   |  | neral Home                               | Maryland                          |
| ä                          | Depe<br>Impo<br>any i   |                | Moderation  |  | 12                                    | 7 South                                    | Main S                            | treet, Nor                                   | th East, Ma                              | ry1and21901                       |
| Н                          |   |                | 23a. Part1. Enter the disease, or complice shock, or heert failure. List only one                           | ations that caused the decause on each line.   | eath. Do not ent                      | er the mode of dyin                        | ng, such as car                   | rdiac or respiratory ar                      | rest,                                    | Approximate<br>Interval Between   |
|                            | Physician   |                | Immediate Cause (Final disease or condition   | Demis  | bull                                  | tion                                       | -                                 |  |  | Unknown                           |
|                            | /Medical<br>Examiner  |                | resulting in death)   | Due to (or as a con-                           | sequence of:                          |  |                                   |  | 1  |                                   |
|                            | Lxammer   | _              | Sequentially list conditions, b.  | CUA  | (cere                                 | provo                                      | soula                             | 000  | (hent)                                   |                                   |
|                            | led<br>Isit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ue to (or as a con-                            | seq = ce of):                         |  |                                   |  |  |                                   |
|                            | al-trar   | xan            | that initiated events c. resulting in death) Last   | Due to (or as a con-                           | sequence of):                         |  |                                   |  |  |                                   |
| 8760,                      | icate be executed<br>physicien and<br>s the burial-transit  | dical          | d   |  |                                       |  |                                   |  |  |                                   |
| 9                          | tificat<br>ng phy<br>as th  | led            |   |  |                                       | -  |                                   |  |  |                                   |
| Вох                        | death certific<br>e ettending pl<br>d for use as t  | an/h           | 23b. Was decedent pregnant  | c. If yes, outcome of pre                      |                                       | Ectopic pregnancy                          | ,                                 |  | 23d. Date of deliv                       | •                                 |
| o.                         | 0 60 9  | Physician/Me   | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant at time of 9□ Unknown               |                                       | Other (specify)                            |                                   |  | Month                                    | Day Year                          |
| 9.                         | ires that the de<br>signed by the e<br>I be detached f  |                | Part II. Other significant conditions cont  | obuting to death but not                       | resulting in the u                    | deriving cause on                          | en in Part I                      | 23e Did to                                   | bbacco use contribute to                 | the cause of death?               |
| ds,                        | The law requires that the<br>ate has been signed by th<br>page 2 should be detache  | d by           |   |  |                                       | inani, ing sasto git                       |                                   |  | res 2□No 3 Pro                           |                                   |
| cor                        | w requir  | Completed      |   |  |                                       |  |                                   | 24a. Was                                     | an 24h Were aut                          | opsy findings available           |
| Be                         | ysician: The lav<br>is certificate has<br>director, page 2  | E G            |   |  |                                       |  |                                   | autop<br>perfo                               | osy prior to c<br>rmed? death?           | ompletion of cause of             |
| ta                         |   | BeC            | 25. Was case referred to medical  |  |                                       |  | 26 Place of                       | 1 ☐ Yes Death (Check only o                  |  | 2□ No                             |
| <u> </u>                   | ysici<br>iis cer<br>direc   | To B           | examiner?   | ospital:<br>1 ☐ Inpatient 2                    | 2 ☐ ER/Outpatien                      | t 3 DOA Oth                                |                                   | /  | dence 6 □Other (Spec                     | ify)                              |
| 0 0                        | Attending Physician: r death. sctor: After this certific. by the funeral director,  |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year        | 28b. Time of<br>Injury                | 28c, Injur<br>Wor                          | y at<br>k?                        | 28d. Describe h                              | now injury occurred                      |                                   |
| sio                        | Attendi<br>death.<br>ctor: A<br>y the fu  | cat            | 2 Accident investigation 3 Suicide 6 Could not be   |  |                                       |  | Yes 2 □ No                        |  |  |                                   |
| Division of Vital Records, | after of Direction by   | Certification: | 4 ☐ Homicide determined   | 28e. Place of Injury - A<br>building, etc. (Sp |                                       | eet, factory, office                       |                                   | City or Tou                                  | Street and Number or Ru<br>vn, State)    | ral Houte Number,                 |
|                            | spital<br>tours<br>neral<br>filled  |                | 29a. Certifier 1 Certifying Physi   | cian: To the best of my                        | knowledge, death                      | occurred at the tin                        | ne, date and p                    | place, and due to the                        | cause(s) and manner as                   | stated.                           |
|                            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | edical         | (Check only 2 Medical Examin one)   | er: On the basis of exam<br>and manner stated. | nination and/or in                    | vestigation, in my o                       | pinion, death                     | occurred at the time,                        | date and place, and due                  | to the cause(s)                   |
|                            | To the To the Comp  | ž              | 29b. Signature and title of certifier   | 1110   |                                       | 29c. Licens                                | e number                          |  | 29d. Date signed (Month                  | Day, Year)                        |
| •                          | _   |                | Clowarge  |  |                                       | DOCO                                       | 6075                              | 6  | 3/25/2                                   | 308                               |
|                            | 1-  |                | 30. Name and address of person who cor  | npleted cause of death (                       | Item 23a) (Type,                      | Print)                                     | Main                              | SI SI  | kon, Ni                                  | 21921                             |
|                            | Sta   | to             | 31. Date filed (Month, Day, Year)   | 22. Registrar's Si                             | gnature                               |  | ( ) (                             | 21.01  | 7,10-2                                   |                                   |
|                            | Registr   |                | MAR 2 6 2008  | Bedie 1  | gnature for                           | K)   |                                   |  |  |                                   |

|   |                | 1 - For State Registrar   | State of Maryla  |                                      | ariment of F<br>rtificate of I                |  |                                       | ene<br>eg. No.                         |  |
|---|----------------|---|--|--------------------------------------|---|--|---------------------------------------|--|--|
| _=_   |                | Decedent's Name (First, Middle, Li  | ast)   |                                      |   |  | 2. Date of Deat                       | h 201                                  | 3. Time of Death                                   |
| Physic<br>/Med  |                | TYWONE  | LARAY SU   | GICK                                 |   |  | Month<br>MARCH                        | 10, 200                                | 8 2300 M   |
| Exam  |                | 4a. Facility Name (If not institution, gi   | ve street and number)  | -                                    |   | Location of Death                          |                                       | 4c. County of                          |  |
|   |                | PRINCE GEORGE'S   |  |                                      |   | EVERLY                                     | T =                                   |  | GEORGE'S   |
| Funera<br>Directo   |                | 291-72-9090   | Sex 7. Age (In y. 15€ M 2 □ F 33   | rs. last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                | If Under 24 Hrs. Hours Min.                | 8. Date of Birth (Month, Day, Aug. 5, | 1974                                   | Birthplace (State or Foreign Country)              |
| land<br>t   |                | Usual Residence of Decedent  10a. State 10b. Counfy   | 10c.   | City, Town or Lo                     | cation  |  |                                       |  | 10d. Inside City Limits                            |
| Mary<br>-f sho  | to             | Md. Prince G  | George's   | Ne                                   | w Carroll                                     | ton.                                       |                                       |  | 1 XYes 2 No  |
| n the   | Director       | 10e. Street and Number  |  |                                      | 10f. Zip Code                                 |  | 10                                    | Og. Citizen of Wha                     | at Country?  |
| th wit<br>23a o<br>1st be   |                | 5501 Kearney I  | ane #1108  |                                      | 2   | 20784                                      |                                       | United                                 | States   |
| tems  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?  | U.S. 13.                             | Was Decedent of H<br>If Yes, specify Cuba     | ispanic Origin? (Span, Mexican, Puerto     | ecify Yes or No-<br>Rican, etc.)      |  | American Indian,<br>White, etc.                    |
| Ind 21215-0036  be filed within 72 hours after death with the Maryland tital Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at | by             | 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1  Yes 2 No<br>If Yes, Give<br>Year or Dates:                                      |                                      | 1 □ Yes 2€ No                                 | Specify:                                   |                                       | Specify:                               | Black  |
| 72 h  | Completed      | 15. Decedent's E<br>(Specify only highest gi  | ducation<br>rade completed)  | 16a. Deced                           | dent's Usual Occup<br>kind of work done       | ation<br>during most of work<br>f)         | ing                                   | 16b. Kind of Busin                     | ness/Industry                                      |
| withir ene.   | E G            | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                      | tore Mana                                     |  |                                       | Manag                                  | ing  |
| filed<br>Hygir<br>Sther   |                | 17. Father's Name (First, Middle, Las   | t)   |                                      |   | 18. Mother's Name                          | e (First, Middle, N                   | faiden Surname)                        |  |
| Irylan<br>should be<br>nd Mental<br>marked o<br>imatic eve  | To Be          | Freddie Mansor  | ı  |                                      |   | Dais                                       | sy Sugi                               | ck                                     |  |
| and and aum   | -              | 19a. Informant's Name/Relationship Daisy Y. Manso   |  | 19b. Mailir<br>1702                  | ng Address <i>(Street i</i><br>Dutch Vil      | and Number or Run<br>lage Driv             | al Route Number,<br>ve Lando          | City or Town, Sta                      | ate, Zip Code)<br>20785                            |
| re, N<br>s 1 and<br>f Health<br>Item 27<br>other tr   |                | 20a. Method of Disposition  | 201  | . Place of Dispo                     | sition (Name of<br>natory or other place      | 100  | Date :                                | 20c. Location - Cit                    | y or Town, State                                   |
| Pages<br>ment of<br>ant: If Its<br>ury or o   |                | 1 ☐ Burial 2X Cremation 3 [<br>4 ☐ Donation 5 ☐ Other (Spec   | _Hemoval from State  | -                                    | e Cremato                                     | 1 2/10                                     | 8/08                                  | Beltsv                                 | ille, Md.  |
| Baltimore, permit. Pages 1 ar Department of Hea Important: If Item: any injury or othe once.  |                | 21. Signature of Funeral Service Los  | ensee/   | 1 1 22                               | 2. Name and Addres                            | ss of Facility Ca                          | apitolMo                              | rtuary,                                | Inc.   |
| n 825 5   |                | Moura A   | HUM Jal  | lly 1                                | 425 Mary                                      | land Ave.                                  |                                       |  | 20002  |
|   |                | 23a. P J.1. Enter the disease or or shock, or heart failure. is no                                  | nplications that caused the de<br>y one cause on each line.                        | eath. 📝 n t ent                      | er the mode of dyin                           | g, such as cardiac                         | or respiratory arre                   | est,                                   | Approximate<br>Interval Between<br>Onset and Death |
| Physician   |                | Immediate Cause (Final disease or condition resulting in death)                                     | a. obstra  | ture                                 | hydr  | ceshal                                     | 22                                    |  | Oriset and Death                                   |
| /Medical<br>Examiner  |                | resulting in death)   | Due to (or as a cons   |                                      | , 0   | 2  |                                       |  |  |
| San San A   | Į.             | Sequentially list conditions if any leading to immediate  | b. Due to (or as a cons  |                                      | 19021   | 2  |                                       |  |  |
| uted  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  | ,                                    |   |  |                                       |  |  |
| 68/6U, tificate be executed g physician and as the burial-transit   | Exa            | resulting in death) Last  | C. Due to (or as a cons  | equence of):                         |   |  |                                       |  |  |
| <b>68 / 6U</b> fircate be e   | ledical        |   | d  |                                      |   |  |                                       |  |  |
|   |                | IF FEMALE:  |  |                                      |   |  |                                       |  |  |
| Ords, P.O. BOX 6 requires that the death certificen signed by the attending thould be detached for use as   | Physician/IV   | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome pf preg<br>1☐Live birth 2☐Fe                                  | etal death 3                         | Ectopic pregnancy                             | ,  |                                       | 23d. Date of                           |  |
| at the dea  | /sici          | 1 Yes 2 No  | 4□Pregnant at time o<br>9□Unknown  | ifdeath 5□                           | Other (specify)                               |  |                                       | WOULT                                  | Day Teal   |
| that the ed by detac  | Ph             | Part II. Other significant conditions   | contributing to death but not r  | esulting in the u                    | nderlying cause give                          | en in Part I.                              | 23e. Did tob                          | acco use contribu                      | ute to the cause of death?                         |
| COLDS, P  | d by           |   | •  |                                      | , ,   |  | 1 □ Ye                                | es 2∐No 3[                             | ☐ Probably 4 ☐ Unknown                             |
| 2 2 2   | Completed      |   |  |                                      |   |  | 24a. Was ar                           | 24b. We                                | re autopsy findings available                      |
| (a) (b) (c)   | шс             |   |  |                                      |   |  | autops:<br>perforn                    | y prio                                 | or to completion of cause of the other interests.  |
|   | Be C           | 25. Was case referred to medical  |  |                                      |   | 26. Place of Deatl                         |                                       |  | Yes 2□ No  |
| <u>~</u> ≥ .≦ ⊟   | To E           | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 Inpatient 2  | ☐ ER/Outpatien                       | t 3 DOA Othe                                  | er: 4 ☐ Nursing Ho                         | me 5 Reside                           | nce 6 Other                            | (Specify)  |
| n Ol<br>ng Phy<br>Mer thi<br>Ineral (   |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury               | Worl  |  | 28d. Describe ho                      | w injury occurred                      |  |
| SIO<br>teath.<br>tor: A   | cati           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   |  |                                      |   | Yes 2 □ No                                 |                                       |  | -  |
| LIVISION tal or Attending s after death. al Director: Afte  | Certification: | 4 ☐ Homicide determined   | building, etc. (Spe  | cify)                                |   |  | City or Town                          | , State)                               | or Rural Route Number,                             |
| LIVISION Of the Hospital or Attending Ph hin 24 hours after death, the Funeral Director: After it mpletely filled in by the funeral   | Medical        | 29a. Certifier 1 de CertifyIng P (Check only 2 de Medical Exa                                       | hysician: To the best of my k<br>miner: On the basis of exam<br>and manner stated. | nowledge, death<br>ination and/or in | n occurred at the tir<br>vestigation, in my o | ne, date and place,<br>pinion, death occur | and due to the cared at the time, da  | ause(s) and mann<br>ate and place, and | er as stated.<br>d due to the cause(s)             |
| To the I<br>within 2<br>To the I  | Me             | 29b. Signature and title of certifier   | 0  | /.                                   | 29c. License                                  | e number                                   | 29                                    | d. Date signed (/                      | Month, Day, Year)                                  |
|   |                | Karen   | - 0100   | V                                    | D4  | 9183                                       |                                       | 3/11/0                                 | 8  |
| RU)   |                | 30. Name and address of person who Dr. Karen Brook  | completed cause of death (It   | em 23a) (Type,                       | Print)<br>FIVE C                              | heverly                                    | MD,                                   | 20785                                  |  |
|   | ate            | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sig  | nature                               |   |  |                                       |  |  |
| Regist  |                | MAR 2 1 2008  | Bleve &  | mare                                 |   |  |                                       |  |  |
| DHMH 17 Rev 1/  | 2001           |   | •  | •                                    |   |  |                                       |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Joseph Steiner March 16 2008 8:10a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alfred House Elder Care Rockville Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F 577-12-9902 92 10/26/1915 Director Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Ves 2 No Directo Maryland | Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18709 Bloomfield Road 20832 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ★Yes 2 No If Yes, Give Year or Dates: 1944 1 ☐ Never Married 2 Married 1 ☐ Yes 2 HNo Baltimore, Maryland 21215-0036 "natural", or Specify: White Š Ĩ946 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Recording Sound Engineer American Broadcasting (o. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Steiner Maria Raiger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is Elizabeth Steiner/Wife 18709 Bloomfield Road, Olney, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 3/20/2008 4 Donation 5 Dother (Specify) Brentwood, MD of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signatur 3401 Bladensburg Road, Brentwood, MD 20722 Approximate Interval Between Onset and Death 2 months 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary Hypertension **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 9☐ Unknown 9 Hinknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed Diabetes Melitus 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? certificate Cerebro Vascular Accident 1□ Yes r Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

the within 2

Division or Vital Records. P.O. Box 68760.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR 2 1 2008

David B. Harding, M.D. 18111 Prince Philip Dr., Ste 300, Olney, MD 32. Registrar's Signat

30. Name and address of pason who completed cause of death (Ite n 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician MELVIN H. SPENCER 03/16/2008 1:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

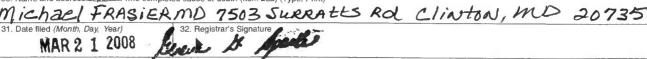
Months Days Hours Min. 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215-36-2782 71 Director MARYLAND 05/13/1936 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD PRINCE GEORGES CAPITOL HEIGHTS Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 5825 COOLIDGE STREET 20743 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ∏Yes 2∭X No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Specify. þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) GRAPHICS PRINTER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELMER SPENCER MARION WINDSOR 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH SPENCER/SON 5825 COOLIDGE STREET CAPITOL HEIGHTS, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot CHIERCHY, GENERAL CEMETERY 03/22/2008 LAPLATA, MD Nurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) erebra /Medical Due o (or as a consequence of) Examiner Due to or as a consequence of Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 perform certificate 2 No Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) P 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0065111

Registrar
DHMH 17 Rev 1/2001

DK

State

SOUTH DIVISION SUIT BSMISBURSMO 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415

32. Registrar's Signature

SVETTANN GUTTORRES

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                   |  |                | 1 - For State Registrar  |  | f Marylar                          | nd / Depa                           |                           | t of H                    | ealth ai                       |                         | ental Hyg                        |                         | _                                       | * discourse * development * de | 5   3     |
|-------------------|--|----------------|--|--|------------------------------------|-------------------------------------|---------------------------|---------------------------|--------------------------------|-------------------------|----------------------------------|-------------------------|---|--|-----------|
| . *               | Physici  | an             | 1. Decedent's Name (First, Middle,   | Last)                                  |                                    |                                     | <u>-</u>                  |                           |                                | 2                       | 2. Date of Dea<br>Month          | ith<br>Day              | Year                                    | 3. Time of   | Death     |
| The same          | /Medi  |                |  | Bertha                                 |                                    | ence                                |                           |                           |                                |                         | April_                           | 1                       | 2008                                    | 0245   | A M       |
|                   | Examir   | ner            | 4a. Facility Name (If not institution,   |  | mber)                              |                                     | ,                         |                           | Location of                    | Death                   |                                  |                         | County of Deat                          | h  |           |
| 1,2               |  |                | Laurelwood Car   | e Center                               | 7. Age (In yrs.                    | last hirthday)                      |                           | kton                      | If Under 24                    | 4 Hrs. I s              | . Date of Birth                  |                         | Cecil                                   | npla <i>ce (State</i> o  | v Faraian |
| 30                | Funeral<br>Director  | ,              | 218-26-3410 Usual Residence of Decedent  | 1 □ M 2 X F                            | 78                                 | Yrs.                                | Months                    |                           |                                | Min.                    | Month, Day<br>ay 13,             | (, Year)                | I. Co                                   | ryland   | r roreign |
|                   | yland  |                | 10a. State 10b. County   |  | 10c. C                             | ity, Town or Lo                     | ocation                   |                           |                                |                         |                                  | -                       |   | 10d. Inside Ci   | •         |
|                   | B Ma   | ctor           | Maryland Ceci  | 1                                      |                                    | E1kton                              |                           |                           |                                |                         |                                  |                         |   | 1 <b>X</b> Yes   | 2 🗌 No    |
|                   | or 28  | Director       | 10e. Street and Number   |  |                                    |                                     | 10f. Zip                  | Code                      |                                |                         |                                  | 10g. Citiz              | en of What Co                           | untry?   |           |
|                   | ath w  | E              | 100 Laurel Dri   |  |                                    |                                     |                           | 1921                      |                                |                         |                                  |                         | nited S                                 |  |           |
|                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinate must be neithed at ADES.  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☐ Married                                   | Armed Fo                               | edent Ever in U<br>rces?<br>2 M No | J.S. 13.                            | Was Deced<br>If Yes, spe- | dent of His<br>cify Cubar | spanic Origii<br>n, Mexican, I | in? (Speci<br>Puerto Ri | fy Yes or No-<br>can, etc.)      | 14                      | 4. Race - Ame<br>Black, White           |  |           |
| 21215-0036        | al'.o  | þ              | 3 X Widowed 4 □ Divorced   | If Yes, Giv<br>Year or D               | / <del>e</del>                     |                                     | 1 ☐ Yes                   | 2 <b>X</b> No             | Specify:                       |                         |                                  | 3                       | Specify: W                              | hite   |           |
| ည်                | 72 hc<br>natur   | eted           | 15. Decedent's (Specify only highest   |  |                                    | 16a. Dece                           | dent's Usu                | ai Occupa                 | tion<br>uring most o           | of working              |                                  | 16b. Kin                | d of Business/                          | ndustry  |           |
| 121               | vithin<br>ne.<br>hen   | Completed      | Elementary/Secondary (0-12)  | College (1                             | I-4or 5+)                          |                                     |                           |                           | uring most o                   |                         |                                  | т                       | II 0                                    | 17   |           |
| 22                | Hygie<br>ther t  | ပိ             | 10<br>17. Father's Name (First, Middle, La   | est)                                   |                                    | H.                                  | omema                     |                           | 19 Mother's                    | s Namo /                | First, Middle,                   |                         | Her Ow                                  | n Home   |           |
| Maryland          | d be annual  | o Be           | Oliver Blakele   | ,                                      |                                    |                                     |                           |                           |                                | e Cu                    |                                  | Maidell                 | omanie)                                 |  |           |
| چ                 | shout<br>nd Me<br>mark   | ြ              | 19a. Informant's Name/Relationship   |  |                                    | 19b. Maili                          | ng Address                | (Street a                 |                                |                         |                                  | r. City or              | Town, State, 2                          | ip Code)   |           |
| Ž                 | nd 2<br>alth a<br>27 Is<br>r trau  |                | Michele Hill/G   | randdaugl                              | iter                               |                                     |                           |                           |                                |                         | gton, l                          |                         | 21651                                   | ,,   |           |
| Baltimore,        | s 1 a<br>of Hei<br>Item  |                | 20a. Method of Disposition   |  | 20b.                               | Place of Disno                      | sition (Nar               | ne of                     |                                | Dat                     | te                               |                         | ation - City or                         | Town, State  |           |
| Ē                 | Page<br>nent c   |                | 1 X Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                          | ∴ Hemoval from cify)                   | State Ch                           | cemetery cret<br>erry Hi<br>thodist | ill<br>t Com              | eterv                     | , A                            | pri1                    | 4,                               | Cher                    | rry Hil                                 | 1. MD  |           |
| a                 | permit. Departr Imports any Inji   |                | 21. Signature of Funeral Service Lie   | censee C                               |                                    | 22<br>H-                            | 2. Name ar                | nd Address                | s of Facility                  | unor                    | ale D                            | ٨                       |   |  |           |
| <u> </u>          | 20 E # 9   |                | Busten the   | els Cres                               | man                                | 10                                  | 03 W.                     | Stoc                      | kton                           | Stre                    | als, P.<br>et, Ell               | cton,                   | MD 2                                    | 1921   |           |
|                   |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or           | inplications that cally one cause on e | aused the dea<br>ach line.         | th. Do not ent                      | ter the mod               | le of dying               | , such as ca                   | ardiac or I             | espiratory arr                   | est,                    |   | Approximate<br>Interval Bette<br>Onset and (   | ween      |
|                   | Physician /Medical   |                | Immediate Cause (Final disease or condition resulting in death)                    | -                                      | ZESUM                              |                                     | Myou                      | 4ROLA                     | 1 11                           | NFAR                    | CTION                            | 7                       |   | Onset and t  | 76401     |
| 4                 | Examiner   |                |  | Due to                                 | (or as a consec                    |                                     |                           |                           |                                |                         |                                  |                         |   |  |           |
|                   |  | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to                              | or as a consec                     |                                     |                           |                           |                                |                         |                                  |                         |   |  |           |
|                   | uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events       |  | COP                                | <b>D</b>                            |                           |                           |                                |                         |                                  |                         |   |  |           |
| o Î               | ate be executed hysicien and the burial-transit  | Exa            | resulting in death) Last   | Due to (                               | or as a consec                     | quence of):                         |                           |                           |                                |                         |                                  |                         |   |  |           |
| 8760,             | ate be<br>hysici   | lical          |  | d.                                     |                                    |                                     |                           |                           |                                |                         |                                  |                         |   |  |           |
|                   | entific<br>ling p  | Med            | IF FEMALE:   |  |                                    |                                     |                           |                           |                                |                         |                                  | -                       |   |  |           |
| Box               | The law requires that tha death certificat ate has been signed by the attending phy page 2 should be detached for use as the   | Physician/Med  | 23b. Was decedent pregnant in the past 12 months?                                  |  | irth 2 Feta                        | al death 3                          | Ectopic pr                |                           |                                |                         |                                  | 23                      | 3d. Date of deli<br>Month               | .,   | r ear     |
| o.                | tha de   | ysic           | 1 ☐ Yes ☐ No<br>9 ☐ Unknown  | 4⊟ Pregn<br>9⊟ Unkno                   | ant at time of o                   | death 5                             | Other (sp                 | овсіту) <sub></sub>       |                                |                         |                                  |                         |   | ĺ  |           |
| <b>Q</b> .        | res that tha de<br>signed by the a<br>l be detached f  |                | Part II. Other significant conditions  | s contributing to de                   | eath but not res                   | sulting in the u                    | nderlying c               | ause give                 | n in Part I.                   |                         | 23e. Did to                      | bacco us                | e contribute to                         | the cause of d   | eath?     |
| of Vital Records, | quires<br>n sign   | d by           |  |  |                                    |                                     |                           |                           |                                |                         | 1 🗆 Y                            | es 2 🗆                  | No 3□Pro                                | bably 4-t  | ที่known  |
| 000               | aw requir<br>s been si<br>2 should   | olete          |  |  |                                    |                                     |                           |                           |                                |                         | 24a. Was a                       | ın                      | 24b. Were au                            | topsy findings   | available |
| æ                 | sician: The lav<br>certificate has<br>irector, page 2 :  | Completed      |  |  |                                    |                                     |                           |                           |                                |                         | autops<br>perform                | med?                    | prior to death?                         | ompletion of ca  | ause of   |
| ta                | ian:<br>ortifice<br>ctor, p  | Bec            | 25. Was case referred to medical examiner?   | -                                      |                                    |                                     |                           |                           | 26. Place o                    | of Death (              | Check only or                    |                         | 1 | 110  |           |
| <u>&gt;</u>       | hysic<br>his ce<br>il dire   | 인              | 1 ☐ Yes 2 ☐ No   | Hospital: 1 □ I                        | npatient 2                         | ER/Outpatier                        | nt 3□ DC                  | Other                     | Nurs                           | sing Home               | 5 🗆 Reside                       | ence 6                  | □Other (Spec                            | eify)  |           |
| n o               | Attending Physician: or death. ector: After this certifici by the funeral director.  | iuo<br>i       | 27. Manner of Death 1-□Natural 5 □ Pending   | V 1                                    | of Injury<br>th, Day Year)         | 28b. Time o<br>Injury               |                           | 8c. Injury<br>Work        | at<br>?                        | 28                      | d. Describe h                    |                         |   |  |           |
| Division          | ttend<br>death<br>stor: /  | icat           | 2 Accident investigat 3 ☐ Suicide 6 ☐ Could not                                    | by Diese                               | of Injury - At h                   |                                     | M                         |                           | es 2⊡No                        |                         | f I continu (C                   |                         | Aleman D.                               | -10- 11  |           |
| <u>&gt;</u>       | or Attendation of a start of a st | Certification: | 4 Homicide determine   | buildir                                | ng, etc. (Speci                    | fy)                                 | eet, ractory              | y, onice                  |                                | 20                      | City or Town                     |                         | Number or Ru                            | rai rioule ivum  | der,      |
|                   | To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by  | edicai C       | 29a. Certifier e la (Check only 2 Men x one)                                       | Physician: Tulthe<br>a ner: On the ba  | asis of examina                    | owladge, deat<br>ation and/or in    | vestigation               | at the turns, in my opi   | a, data and i                  | place, an               | d due to the c<br>at the time, d | ause(s) a<br>late and p | nd manner as<br>place, and due          | stateu.<br>to the cause(s  | )         |
|                   | o the<br>o the<br>omple  | Med            | 29b. Signature and title of certifier  | and mans                               | iei stated.                        |                                     |                           | . License                 |                                | -                       |                                  |                         | signed (Month                           |  |           |
|                   | ĕ⊣≰⊣   |                | ) // #/ a  | Á                                      |                                    |                                     | Î                         | 540                       | 73                             |                         |                                  | 011                     | 49208                                   | 3  |           |
| •                 |  |                | 30. Name and address a person wh   | no completed caus                      | e of death (Iter                   | m 23a) (Type.                       |                           |                           |                                | ,                       |                                  |                         |   |  |           |
| _                 |  |                | ALLEN STONE,   | MO                                     | 81                                 |                                     | 2CHM                      | ک ک                       | DA                             | Na                      | J 61576                          | E D                     | 4PRO8                                   | 120  |           |
| 10 to             | Sta  |                | 31. Date filed (Month, Day, Year)  | 32                                     | egistrar's Sign                    | ature                               | 100 Z-                    |                           |                                |                         |                                  |                         |   |  |           |
| 1                 | Registr  | ar             | AFE U SI &   | UUD LOS                                | 10000 /3                           |                                     |                           |                           |                                |                         |                                  |                         |   |  |           |

DHMH 17 Rev 1/2001

ORIGINAL

|                   |  |                | For State  | State of Ma                               | ryland /         |               | nent of F<br>cate of                    |                                     | d Mental H                             | Hygien<br>Reg. N    | -/-                | 008                        | 1161                                   |
|-------------------|--|----------------|--|---|------------------|---------------|---|-------------------------------------|--|---------------------|--------------------|----------------------------|--|
|                   |  |                | Registrar  1. Decedent's Name (First, Middle, Last)                    | st)                                       |                  |               | -                                       |                                     | 2. Date of                             |                     | <u> </u>           |                            | 3. Time of Death                       |
|                   | Physic   |                | Elizabeth Antoinette   |   |                  |               |   |                                     | Month                                  | h 21,               | <sup>ay</sup> 2008 | Year                       | 4:55 p <sup>M</sup>                    |
| 1                 | /Medi<br>Exami   |                | 4a. Facility Name (If not institution, give                            |   |                  | 4b            | City, Town, o                           | r Location of De                    |  |                     | c. County          | of Death                   | 4.33 P                                 |
|                   | Exami  | 161            | Woodside Genesis Rel   | ab. Center                                |                  | Silv          | er Sprin                                | a                                   |  |                     | Mon                | tgomer                     | v                                      |
| 45                | Funeral  |                | 5. Social Security Number 6. S   |   | (In yrs. last bi | irthday) If   | Under 1 Year                            | If Under 24 H                       | rs. 8. Date of                         | Birth<br>Day, Yea   |                    |                            | ace (State or Foreign<br>ry)           |
| 0                 | Director   |                | 579-36-1596  | □M 2X□F .                                 | 77               | Yrs.          | onths Days                              | Hours N                             |  | 22, 19              | 930                | Washin                     | gtan, DC                               |
|                   | p.   |                | Usual Residence of Decedent  |   |                  |               |   |                                     |  |                     |                    |                            |  |
|                   | arylar<br>show   | _              | 10a. State 10b. County   |   | 10c. City, Tov   | vn or Locatio | n                                       |                                     |  |                     |                    | 10                         | ld. Inside City Limits  1 □ Yes 2 ▼ No |
|                   | 72 hours after death with the Maryland<br>natural, or items 23a or 28a-f show<br>dieal Examiner must be notified at        | Director       |  | ontgomery                                 |                  |               | Spring                                  |                                     |  |                     |                    |                            |  |
|                   | or 2   | Ę.             | 10e. Street and Number   |   |                  | 1             | Of. Zip Code                            |                                     |  | 10g. C              | itizen of W        | hat Count                  | ry?                                    |
|                   | ath w<br>23a<br>ust l  | <u>ra</u>      | 1400 Fenwick Lane, A   | _   |                  |               | 0910                                    |                                     |  |                     | USA                |                            |  |
|                   | tems<br>er de  | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?       |                  | 13. Was       | Decedent of F<br>s, specify Cub         | lispanic Origin?<br>an, Mexican, Pu | ' (Specify Yes or<br>uerto Rican, etc. | No-                 |                    | e - America<br>k, White, e |  |
| 36                | s afte   | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                 | 1 ☐ Yes 2 🔀 No<br>If Yes, Give            | 0                | 1 🗆 '         | Yes 2√x No                              | Specify:                            |  |                     | Specify            | White                      |  |
| 21215-0036        | hours<br>ural  | Q p            |  | Year or Dates:                            | 16               | Docadent'     | s Usual Occur                           | ation                               |  | 16h                 | Vind of Du         | siness/Ind                 | tm.                                    |
| 15-               | "nat   | lete           | 15. Decedent's Ed<br>(Specify only highest gra                         | de completed)                             |                  | (Give kind    |   | during most of                      | working                                | 100.                | KIIIU OI DU        | 5111 <b>6</b> 55/1110      | ustry                                  |
| 12                | within iene. than "  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+                         | -)               |               | emaker                                  | -/                                  |  |                     | Own :              | Ll <b>o</b> mo             |  |
|                   | filed<br>Hygi<br>Ither   |                | 17. Father's Name (First, Middle, Last)                                | 1   |                  | IIOI          | enoxer                                  | 18. Mother's I                      | Name (First, Mic                       | ldle, Maide         |                    |                            |  |
| an                | d be<br>ental<br>ced o   | To Be          | Frank Gilmore Thoma  |   |                  |               | Je                                      | ssie Lela                           | and Foster                             | ^                   |                    |                            |  |
| Maryland          | 12 should be filed v<br>n and Mental Hygie<br>Is marked other t<br>raumatic event, th                                      | F              | 19a. Informant's Name/Relationship (                                   |   | 19               | b. Mailing A  |   |                                     | Rural Route No                         |                     | or Town.           | State, Zip                 | Code)                                  |
| ∑<br>S            | 5 ± 2 ±  |                | Bonnie L. Poole/Daugh  | ter                                       |                  | _             | ·                                       |                                     | ryland 210                             |                     |                    |                            |  |
| ē,                | ges 1 and 2<br>t of Health<br>If item 27 I   |                | 20a. Method of Disposition   |   | 20b. Place o     |               | n (Name of<br>ry or other pla           | 00)                                 | Date                                   | 20c.                | Location -         | City or Tov                | wn, State                              |
| altimore,         | 0 0 <del>-</del> -   |                | 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif            |   |                  | -             | Cemeter                                 | v hapi                              | ril 9,                                 |                     |                    |                            |  |
| ≣                 |  | (              | 21. Signature of Funeral Service Licer                                 |   |                  | 22. Na        | me and Addre                            |                                     | 008<br>neral Homa                      |                     | Bre                | <u>n twood</u>             | ,Maryland _                            |
| ä                 | permit. Departr Importa any Inji   |                | 1  | Son                                       |                  | 1             |   |                                     | W., Silve                              |                     | ina M              | D 2000                     | 1                                      |
| 15                | 1  |                | 23a. Part1. E er the disease, or com                                   | plications that caused                    | the death. Do    |               |   |                                     |  |                     | ing, m             | 1111                       | Approximate                            |
|                   | Physician  | 15             | shock, or heart failure. List only<br>Immediate Cause (Final           | one cause on each line                    | э.               | _             | 0 -                                     | *                                   |  |                     |                    |                            | Interval Between<br>Onset and Death    |
|                   | /Medical   |                | disease or condition resulting in death)                               | a. Orono  Due to (or as a                 |                  | of).          | de                                      | deuse                               |  |                     |                    |                            |  |
|                   | Examiner   |                |  | Penir                                     | sheral           | 2 VC          | esceul                                  | sease an di                         | 18010                                  |                     |                    |                            |  |
|                   |  | ē              | Sequentially list conditions, if any, leading to immediate             | b. Due to (or as a                        | consequence      |               |   |                                     |  |                     |                    |                            |  |
|                   | uted<br>J<br>ansit   | Ē              | cause. Enter Underlying Cause (Disease or injury that initiated events |   |                  |               |   |                                     |  |                     |                    |                            |  |
| Ć,                | exec<br>n and<br>ial-tra   | Examiner       | resulting in death) Last   | Due to (or as a                           | consequence      | e of):        |   |                                     |  |                     |                    |                            |  |
| 68760,            | eath certificate be executed attending physician and for use as the burial-transit   | edical         |  | d.  |                  |               |   |                                     |  |                     |                    |                            |  |
|                   |  | edi            |  |   |                  |               |   |                                     |  | 1                   |                    |                            |  |
| Box               | andin<br>use   | 1              | IF FEMALE:<br>23b. Was decedent pregnant                               | 23c. If yes, outcome p                    |                  |               |   |                                     |  |                     | 23d. Dat           | e of delive                | ry                                     |
|                   | deatle<br>e atte<br>d for  | icia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                               | 1□Live birth 2<br>4□Pregnant at t         |                  |               | opic pregnanc<br>ner <i>(specify)</i> _ | у                                   |  | _                   | Мо                 | nth                        | Day Year                               |
| P.0               | iaw requires that the death certi<br>as been signed by the attending<br>2 should be detached for use a                     | Physician/M    | 9 ☐ Unknown  | 9∐Unknown                                 |                  |               |   |                                     |  |                     |                    |                            |  |
|                   | s tha<br>ned l   | by P           | Part II. Other significant conditions of                               |   | t not resulting  | in the under  | ying cause giv                          | en in Part I.                       | 23e. [                                 | old tobacco         | use conti          | ibute to the               | e cause of death?                      |
| ğ                 | quire<br>an sig<br>uld b   | b<br>b         | Drabeles me  | elitus,                                   | my               | setee         | mai,                                    | Strok                               | <u>e</u> , 1                           | ☐ Yes               | 2□ No              | 3 ☐ Proba                  | ably 4 Inknown                         |
| 000               | aw requir<br>s been si<br>s should   | Completed      |  |   | 0                |               |   |                                     |  | Vas an              | 24b. \             | Vere autop                 | osy findings available                 |
| Re                | The lav  | E C            |  |   |                  |               |   |                                     | _ r                                    | utopsy<br>erformed? | / (                | leath?                     | npletion of cause of                   |
| or Vital Records, |  |                | 25. Was case referred to medical                                       |   |                  |               |   | 26 Place of                         | 1  You                                 |                     | 10                 | ∐Yes                       | 2 □ No                                 |
| >                 | Physician:<br>this certificaral director, I  | To Be          | examiner?<br>1 ☐ Yes 2 ☑ No  | Hospital: 1 ☐ Inpatier                    | ıt 2□ER/O        | utpatient 3   | DOA Oth                                 |                                     | g Home 5□ F                            |                     | 6 □Oth             | er (Specific               | 4)                                     |
| 0                 | a Phy<br>er thi  |                | 27. Manner of Death  | 28a. Date of Injury                       | y 28b.           | Time of       | 28c. Inju<br>Wo                         |                                     | 28d. Descr                             |                     |                    |                            | /                                      |
| Division          | or Attending I<br>ifter death.<br>Director: After<br>in by the funer   | ţ              | 1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investigation                  | (Month, Day                               | rear)            | Injury I      |   | Yes 2 No                            |  |                     |                    |                            |  |
| S                 | Attend<br>r death<br>ector:  | fice           | 3 Suicide 6 Could not be<br>4 Homicide determined                      | 286. Place of injul                       |                  | arm, street,  | factory, office                         |                                     |  |                     |                    | er or Rurai                | Route Number,                          |
| Ö                 | al or<br>s afte  | Certification: | 4 Dirioniioide   | building, etc.                            | . (эрвспу)       |               |   |                                     | City of                                | Town, Sta           | (le)               |                            |  |
|                   | ospita<br>hours<br>mera<br>y fille   |                | 29a. Certifier 1 Certifying Ph   | ysician: To the best o                    | f my knowledg    | ge, death oc  | curred at the ti                        | me, date and p                      | lace, and due to                       | the cause           | (s) and ma         | nner as st                 | ated                                   |
|                   | n 24 l   | Medical        | (Check only 2 ☐ Medical Examone)                                       | niner: On the basis of<br>and manner stat |                  | ind/or invest | gation, in my                           | opinion, death o                    | occurred at the t                      | me, date a          | ind place,         | and due to                 | the cause(s)                           |
|                   | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu | Me             | 29b. Signature and title of certifier                                  |   |                  |               | 29c. Licens                             |                                     |  | 29d. E              | ate signed         | i (Month, L                | Day, Year)                             |
|                   |  |                | . 1/   | -   |                  |               | 1                                       | D65301                              |  |                     |                    |                            |  |

State Registrar

31. Date filed (Month, Day, Year) MAR 2 6 2008

Farzana Ajmal, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



9101 Second Avenue, Silver Spring, MD 20910

|             |  |                | For State   | State of I                                  | Marylan  | -                      | artment of F                               |                             |                           | -                             | _                      | 200                                     | Q !                                     | 1615         |
|-------------|--|----------------|---|---|--|------------------------|--|-----------------------------|---------------------------|-------------------------------|------------------------|---|---|--------------|
|             |  |                | Registrar  1. Decedent's Name (First, Middle, L   | ast)  |  | 061                    | inicate or                                 | Dealli                      |                           | 2. Date of De                 | Reg. No.<br>ath        | 200                                     | 3. Time                                 | of Death     |
| ľ           | Physici<br>/Medic  |                | James V   | Villiam                                     | W  | eston,                 | Jr.  |                             |                           | Month<br>March 3              | Day                    |   |   |              |
|             | Examir   |                | 4a. Facility Name (If not institution, g  | ive street and number                       |  |                        | 4b. City, Town, o                          | r Location of               |                           | Iai Cii                       |                        | County of De                            |   | 5 p          |
| 100         |  | ñ,             | Charlotte Hall  |   |  |                        |  | rlott                       |                           | L1                            |                        | St. 1                                   | Mary's                                  |              |
|             | Funeral  |                | ,   | Sex 7.<br><b>X</b> M 2 ☐ F                  |  | last birthday)<br>Yrs. | If Under 1 Year<br>Months Days             | If Under<br>Hours           | 24 Hrs.  <br>Min.         | 8. Date of Birt<br>(Month, Da | th<br>y, Year)         | 9. E                                    | Birthplace (State<br>Country)           | e or Foreign |
|             | Director   |                | Usual Residence of Decedent   |   | 73   | IIS.                   |  |                             | Į.                        | Aug.6,                        | 1934                   | 4 Per                                   | nnsylva                                 | nia          |
|             | yland<br>Iow<br>at   |                | 10a. State 10b. County  |   | 10c. Cit                                       | y, Town or Lo          | cation                                     |                             |                           |                               |                        |   | 10d. Inside                             | City Limits  |
|             | a-fsh<br>ified   | Ş              | Maryland St.  | Mary's                                      |  | Charlo                 | te Hall                                    |                             |                           |                               |                        |   | 1 □ Ye                                  | es 2 No      |
|             | ith the<br>or 28<br>e not  | Director       | 10e. Street and Number  |   |  |                        | 10f. Zip Code                              |                             |                           |                               | 10g. Citi              | zen of What                             | Country?                                |              |
|             | ath w  |                | 29449 Charlotte   | Hall Roa                                    | d  |                        | 20   | 622                         |                           |                               |                        | S A                                     |   |              |
|             | er de<br>items<br>ner m  | Funeral        | 11. Marital Status  | 12. Was Decede<br>Armed Force               | s?   | .S. 13. \              | Vas Decedent of H<br>f Yes, specify Cuba   | lispanic Ori<br>an, Mexicar | gin? (Spec<br>1, Puerto R | ify Yes or No-<br>ican, etc.) | . ]                    | <ol> <li>Race - Ar Black, WI</li> </ol> | nerican Indian,<br>hite, etc.           |              |
| 36          | be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  | 1 X Yes 2 [<br>If Yes, Give<br>Year or Date |  |                        | ∐Yes 2∏kNo                                 | Specify:                    |                           |                               |                        | Specify:                                | White                                   |              |
| 21215-0036  | 2 hou<br>atura<br>cal E  |                | 15. Decedent's I  | Education                                   |  | 16a. Deced             | lent's Usual Occup                         | ation                       |                           |                               | 16b. Ki                | nd of Busines                           | ss/Industry                             |              |
| 215         | within 72<br>lene.<br>than "nat<br>he Medio  | Completed      | (Specify only highest g   | rade completed) College (1-4c               | or 5+)   | (Give<br> ife. L       | kind of work done of NOT use retired       | during mos<br>d)            | t of working              | 9                             |                        |   | ,                                       |              |
| 2           | ed withir<br>/giene.<br>er than<br>t, the Me   | Son            | 12  |   |  |                        | wner/Ope                                   | rator                       |                           |                               |                        | Boatir                                  | ng                                      |              |
| Ind         | be filed y<br>tal Hygie<br>d other i<br>event, tt  | Be             | 17. Father's Name (First, Middle, Las   |   |  |                        |  |                             |                           | First, Middle,                | Maiden                 | Surname)                                |   |              |
| y a         | 2 should be and Mental is marked cranmaric ev  | ۴              |   | illiam                                      | We   | ston                   |  |                             | rion                      |                               |                        | Brown                                   |   |              |
| Maryland    | d 2 sh<br>th and<br>7 is n<br>traun  |                | 19a. Informant's Name/Relationship  | ,   |  |                        | g Address (Street                          |                             |                           |                               |                        |   |   |              |
|             | s 1 and 2 should<br>if Health and Mer<br>Item 27 is marke<br>other traumatic   |                | Jeanne Pavero/D  20a. Method of Disposition   | aughter                                     | 20b. P   | lace of Dispos         | Eagle To Sition (Name of                   | i                           | Court<br>Da               | , Wald                        |                        |   | 0602<br>or Town, State                  |              |
| Θ           | 00   |                | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec   |   | te   |                        | natory or other place<br>Veterans          | · :                         | 4/8/2                     | 008                           |                        | •                                       |   |              |
| altimore,   | # 돌편을 .  |                | 21. Signature of Funeral Service Lice   | •   | Trai   | •                      |  |                             |                           |                               |                        |   | m, Mary                                 | yrand        |
| ä           | Depa<br>Impo<br>any Ir   |                | Det CS  | los D                                       | M0081  | $.7 \mid \frac{B}{3}$  | Name and Address<br>rinsfield<br>0195 Thre | d-Echo<br>ee No             | ols F<br>tch R            | uneral<br>d., Ch              | Hom<br>arlo            | e, P.A                                  | 11. MD                                  | 20622        |
|             |  |                | 23a. Part1. Enter the disease, or conshock, or heart failure. List only   | nplications that caus                       | ed the death                                   |                        |  |                             |                           |                               |                        |   | Approxim<br>Interval B                  | nate         |
| T           | Physician  |                | Immediate Cause (Final disease or condition   | atri  | 11   | fih                    | rilla                                      | tio                         | n                         |                               |                        |   | Onset an                                | d Death      |
|             | /Medical<br>Examiner   |                | resulting in death)   | Due to (or a                                | as a g nsequ                                   | uence of):             | 10   | 1                           |                           | ,                             |                        |   | yea                                     | <i>N</i> S   |
|             | 1000   | _              | Sequentially list conditions,   | b. Due to (or a                             | - MU   | me                     | V'S  | de                          | m                         | en ti                         | a                      |   | Vea                                     | WS_          |
|             | ted<br>nsit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to to r                                 | as a consequ                                   |                        | don  | ner                         | かっかっ                      | ,                             |                        |   |   |              |
| <u>,</u>    | execunand nandial-tra  | Exar           | that initiated events<br>resulting in death) Last   | Due to (or a                                | as a consequ                                   |                        |  |                             | 1110                      |                               |                        |   | yea                                     | ars          |
| 8760,       | icate be executed<br>physician and<br>s the burial-transit   | dicall         |   | a he  | 100  | v tes                  | nsion                                      |                             |                           |                               |                        |   | VIE                                     | ars          |
| မှ          | rtificat<br>ng phy<br>as th  | /ledi          | IF FEMALE   |   | ,, -   |                        |  |                             |                           |                               |                        |   | 1 7                                     |              |
| Box         | leath certific<br>attending p  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom                         | ne pf pregna<br>2 □ Fetal                      |                        | Ectopic pregnancy                          |                             |                           |                               | 2                      | 23d. Date of d                          |   |              |
| O.          | the at   | sici           | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant<br>9□Unknown                     | at time of de                                  |                        | Other (specify)                            |                             |                           | <u>_</u>                      |                        | Month                                   | Day                                     | Year         |
| <u>α</u>    | hat the  | Phy            | Part II. Other significant conditions   | contributing to death                       | but not resu                                   | ulting in the un       | derlying cause give                        | on in Bort I                |                           | 220 Did to                    | baasa u                | oo oontribusta                          | 4- 4b                                   | £ d = =45 0  |
| Records,    | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Completed by   | Dentic  | 11/10                                       |  | use                    |  | on in raiti,                |                           |                               | es 2                   |   | to the cause of Probably 4              | Unknown      |
| CO          | w request  | etec           | 7 7 7   |   | ,  |                        |  |                             |                           | -                             |                        |   |   |              |
|             | sician: The law<br>certificate has birector, page 2 s  | mc             |   |   |  |                        | ·  |                             |                           | 24a. Was a<br>autop           | sy<br>med2             | prior to<br>death                       | autopsy finding<br>o completion of<br>? | cause of     |
| Vita        | an: 7<br>tificat<br>tor, pa  |                | 25. Was case referred to medical  |   |  |                        |  | 26 Place                    | of Dooth (                | 1□ Yes<br>Check only or       | 2 No                   | 1 □ Ye                                  | s 2∏No                                  |              |
| >           | ysician: The lis certificate hadirector, page  | o Be           | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1   Inpa                          | tient 2 🗆 I                                    | ER/Outpatient          | 3 □ DOA Othe                               |                             | _                         | e 5 ☐ Resid                   |                        | S □Other (Sc                            | necify)                                 |              |
| Division or | ding Phys  | L II           | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending   | 28a. Date of Ir<br>(Month, L                | njury<br>Day Year)                             | 28b. Time of Injury    | 28c. Injury<br>Work                        |                             |                           | d. Describe h                 |                        |   | ,,                                      |              |
| Sio         | tendi<br>eath.<br>Ior: A<br>the fu   | catio          | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | 0 1   |  |                        | M   1□`                                    | Yes 2□N                     | No                        |                               |                        |   |   |              |
| <u>&gt;</u> | or Attendater death<br>Director:<br>in by the  | Certification: | 4 ☐ Homicide determined   | 20e. Place of I                             | njury - At ho<br>etc. <i>(Sp</i> ec <i>ify</i> | me, farm, stre         | et, factory, office                        |                             | 28                        | f. Location (S<br>City or Tow | treet and<br>n, State) | d Number or I                           | Rural Route Nu                          | ımber,       |
|             | spital<br>ours a<br>neral l  | - 1            | 29a, Certifier 1 Certifying P   | hysician: To the bes                        | st of my know                                  | wledge death           | occurred at the tim                        | ne date an                  | d place, an               | ud duo to the s               | 20000(0)               | and                                     |   |              |
|             | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,         | Medical        | (Check only 2 Medical Exa   | miner: On the basis<br>and manner:          | of examinat                                    | ion and/or inv         | estigation, in my o                        | pinion, dea                 | th occurred               | at the time, o                | date and               | place, and di                           | as stated.<br>ue to the cause           | e(s)         |
|             | To the Hospital within 24 hours a To the Funeral C completely filled   | Me             | 29b. Signature and title of certifier   | Q.P   | *  |                        | 29c. License                               | number                      |                           | 2                             | 29d. Date              | signed (Mor                             | nth, Day, Year)                         |              |
|             |  |                | Janel   | Sten  | w  | 7                      | 10-4                                       | 1509                        | 72                        |                               | 3-                     | - 31                                    | -200                                    | 28           |
|             |  |                | 30. Name and address of person who  | completed cause of                          | death (Item                                    | 23a) (Type, F          |  | 7).                         |                           |                               | 0                      |   | -200<br>MD                              | 0 :          |
|             |  |                | 110 tto8p1 tal 31. Date filed (Month, Day, Year)  | Road  | trar's Signat                                  | ente                   | 205  | Mir                         | nce                       | Trea                          | der                    | ick                                     | MD                                      | 1067         |
|             | Stat<br>Registra   |                | 31. Date filed (Month, Day, Year)  APR 0 2 2006   | See 2 2. Hegis                              | stat s olgnat                                  | and a                  |  |                             |                           |                               |                        |   |   |              |
|             |  |                | 4 MR 11 1000  | -   |  |                        |  |                             |                           |                               |                        |   |   |              |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 24, 2008 4c. County of Death March James Campbell Walker 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X** M 2□ F 527-32-6077 86 March 30, 1921 Delaware Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Delaware New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19711 USA 16 Longview Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify. 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Iron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Campbell Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Rahway Drive, Newark, DE 19711 Patrick Walker/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4-3-2008 1 Nation 2 Nation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delaware Veteran Memorial Cem. Bear, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Foard and Jones, Inc. W. Main Street, Newark, R. 122 DE 19711 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ocuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD ears Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ussase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery dent pregnant 3 Ectopic pregnancy Month 12 months? Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at show

r than "natural", or items 23a or the Medical Examiner must be

I Hygiene. other than "

Ith and Mental F 27 is marked oth r traumatic ever

Pages 1 and 2 should be ment of Health and Menta ant: If item 27 is marked lury or other traumatic ev

permit. Page Department or Important: If any injury or

Director

Funeral

Completed by

Be

2

filed within 72 hours after death with the Maryland

be 1

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and burial-trar

physician

as the attending |

detached

should be

page 2

in by the funeral

Certification:

Medical

certificate

this

After

after death

within 24 hours a To the Funeral I

Physician:

or Attending

Examine Physician/Medical þ Completed Be P

1 ☐ Yes 2 No

5 ☐ Pending investigation

6 Could not be determined

27. Manner of Death

1 🗱 Natural 2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier

|  | 26. Place of Death (Check only one) |        |                       |                       |                    |  |  |  |  |  |  |  |
|--|-------------------------------------|--------|-----------------------|-----------------------|--------------------|--|--|--|--|--|--|--|
| Hospital: 1 ☐ Inpatient 2                | ☐ ER/Outpatient                     | 3 □ DC | OA Other: 4 Nursing H | ome 5 Residence       | 6 ☐Other (Specify) |  |  |  |  |  |  |  |
| 28a. Date of Injury<br>(Month, Day Year) | 28b. Time of<br>Injury              | M 2    |                       | 28d. Describe how inj |                    |  |  |  |  |  |  |  |

| (Month, Day Year)            | Injury         |           | Work?      |        |               |
|------------------------------|----------------|-----------|------------|--------|---------------|
|                              |                | М         | 1 ☐ Yes    | 2 🗆 No |               |
| 28e. Place of injury - At ho | me, farm, stre | et, facto | ry, office |        | 28f. Location |

| building, etc. (Spec | fy) |
|----------------------|-----|
|                      |     |

| determined         | building, etc. (Specify)  | City or Town, State)                             |
|--------------------|---|--|
| Certifying Physici | an: To the best of my knowledge, death occurred at the time, date and place | e, and due to the cause(s) and manner as stated. |

| 29c. License number | 29d. Date signed (Month, Day, Year) |
|---------------------|-------------------------------------|
| D15314              | March 25, 2008                      |
| Print)              | (7)                                 |
| ce 133 N. Bridg     | se ST; Elkton, MD 21921             |
|                     |                                     |
|                     |                                     |
|                     |                                     |
|                     | D15314                              |

|                 | (7 <u>`</u> '_' | 10        | 01400       | , /     | •                  |            |      |
|-----------------|-----------------|-----------|-------------|---------|--------------------|------------|------|
| 30. Name and ad | dress of        | person wh | o completed | cause o | f death (Item 23a) | (Type, Pri | int) |

Registrar

State

5HVA

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 8.06 AM **Physician** 2008 AKCIT 22 Warner Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Lanham Doctors Community Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1X M 2□ F 56 12/15/1951 Maryland 212-60-0164 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1XiYes 2 □ No Upper Marlboro Director Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 USA 15018 Greenwing Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1971-73 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify. Baltimore, Maryland 21215-0036 Be Completed by Black 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Pest Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Pest Control Technician Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 John Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15018 Greenwing Terr Upper Marlboro, Maryland ce of Disposition (Name of Date 20c. Location - City or Town, State Alisha Warner/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4/01/08 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Farenal Service Licensee 20605 Aquasco Rd, Aquasco, Maryland 20608 191\_ 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed **∀**ZLYes 2 □ No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division or Vital Records, P.O. Box 68760, 24 hours a To the

> MP 441VA State

DHMH 17 Rev 1/2001

Registrar

cal

MOHAMMAS

29b. Signature and title of certifier

29a. Certifier

Medianimadali khan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BELLE BINT DRIVE GREENBELTMO DOTTO

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If flem 27 Is marked any injury or other to once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LANITRA MCCONNELL/GRANDDAUGHTER 9711 SUMMIT CIRCLE LARGO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 03/20/2008 | RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MALIGNANT NECK MASS **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be XXNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes XX No 24a. Was an has autopsy performe 1□ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home & Residence 6 Other (Specify) 2**X** No in 24 hours area ...
the Funeral Director: After this a ပ 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or A 24 hours after 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier o the Ho within 2/ Medic and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D41978 MARCH 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NADEL TAWOKOLI 4000 MITCHELLVILLE ROAD BOWIE, MD 20716 31. Date filed (Month, Day, Year) State It spark MAR 2 1 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7. Age (In yrs. last birthday)

LARGO

10c. City, Town or Location

68

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give

If Yes, Give Year or Dates:

College (1-4or 5+)

Certificate of Death

LARGO

10f. Zip Code

20774

1 ☐ Yes 2 📉 No

16a, Decedent's Usual Occupation

BEAUTICIAN

Months

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

2. Date of Death

MARCH 11

8. Date of Birth (Month, Day, Year)

Month

18. Mother's Name (First, Middle, Maiden Surname)

ARRABELL WATSON

Day

USA

2008

4c. County of Death

PRINCE GEORGES

JUNE 14, 1939 WASHINGTON, DC

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

16b. Kind of Business/Industry

PRIVATE

9:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

BERNICE WOODS

9711 SUMMIT CIRCLE

9711 SUMMIT CIRCLE

1 ☐ Never Married 2 ☐ Married

3 XWidowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

LESLIE EDWARDS

12TH

5. Social Security Number

10e. Street and Number

10a, State

MD

Director

Funeral

þ

Completed

Be

578**-**54**-**0992 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

1 □ M 2X F

PRINCE GEORGES

Decedent's Education (Specify only highest grade completed)

**Funeral** Director

should be filed within 72 hours after death with the Maryland nd Mental Hyglene.

marked other than "natural", or Items 23a or 28a-f show ns 23a or 28a-f show must be notified at Examiner Medical

|  |                 | For  | State of Maryla  | and / Depa  | artment of H                                  | ealth and N                              | Mental Hy                           | giene                                |   |                    |
|--|-----------------|--|--|---|---|--|-------------------------------------|--------------------------------------|---|--------------------|
|  | ľ               | 1 - State<br>Registrar   |  | Cei   | rtificate of L                                | Death                                    | F                                   | Reg. No./)                           | 00 1  | 1610               |
| Physicis   |                 | 1. Decedent's Name (First, Middle, Las   | t)   |   |   |  | 2. Date of Dea<br>Month             | ath Cay                              | Year 3. Tim   | ne of Death        |
| Physicia<br>/Medic   |                 | Carrie A.  | Watkins  |   |   |  | March 1                             |                                      |   | 30 A <sup>M</sup>  |
| Examin   |                 | 4a. Facility Name (If not institution, give  | street and number)   |   | 4b. City, Town, or                            | Location of Death                        | 1                                   | 4c. County                           | of Death  |                    |
|  |                 | Fairland Nursing   |  |   |   | Spring                                   |                                     | Montgo                               |   | <u>.</u>           |
| Funeral  |                 | Social Security Number     6. Social Security Number                               | ex 7. Age (In y  | rs. last birthday)                                    | If Under 1 Year Months Days                   | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birti<br>(Month, Day     | h<br>y, Year)                        | Birthplace (Sta<br>Country)                             | ate or Foreign     |
| Director   |                 | 578-64-5329 Usual Residence of Decedent  | 61   | Yrs.  |   |  | July 31                             | , 1946                               | Washing   | ton, DC            |
| land<br>ow   |                 | 10a. State 10b. County   | 10c.   | City, Town or Lo                                      | ocation                                       |  |                                     |                                      | 10d. Insid  | le City Limits     |
| Mary<br>f sh   | tor             | Marvland Prince G  | loorgo!s   | Riverdal  | 1 6   |  |                                     |                                      | 1 😡   | Yes 2 □ No         |
| the notif  | Director        | 10e. Street and Number   | eorge s  | KIVELUA.  | 10f. Zip Code                                 |  |                                     | 10g. Citizen of W                    | Vhat Country?   |                    |
| 3a or  | ٥               | 6786 Riverdale Ro  | ad #T-2  |   | 20706   |  |                                     | United                               | States  |                    |
| death<br>ms 2  | Funeral         | 11. Marital Status   | 12. Was Decedent Ever in   | n U.S. 13.  | Was Decedent of Hi<br>If Yes, specify Cuba    | spanic Origin? (Sp                       | pecify Yes or No-                   | 14. Race                             | e - American India                                      | n,                 |
| urs a  | ۾               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                             | Armed Forces? 1 ☐ Yes <b>¾ 元</b> No If Yes, Give Year or Dates:                                |   | if Yes, specify Cuba<br>1 □ Yes 2 🗓 No        | n, Mexican, Puerti<br>Specify:           | o Hican, etc.)                      | Specify.                             | k, White, etc.<br>African Indian<br>African<br>American | can<br>can         |
| 2 hou  | Completed       | 15. Decedent's Ed  | ucation  | 16a. Dece   | dent's Usual Occupa                           | ation                                    | tria a                              | 16b. Kind of Bu                      |   | )                  |
| hin 7  | ble             | (Specify only highest gra  | College (1-4or 5+)   | life. i   | kind of work done on DO NOT use retired       | luring most of wor<br>)                  | king                                |                                      |   |                    |
| d wit  | ρ               | 12 years   |  | Rac   | diologist                                     | Clerk                                    |                                     | Gover                                | nment   |                    |
| al Hy<br>lothe   | Be              | 17. Father's Name (First, Middle, Last)  |  |   |   | 18. Mother's Nam                         | ne (First, Middle,                  | Maiden Surnam                        | e)  |                    |
| Ment<br>Ment<br>arked<br>atic e  | 2               | Eugene Akins   |  |   |   | Mar                                      | y V.                                |                                      | un-a  | avail.             |
| 2 sho<br>and l<br>is ma  |                 | 19a. Informant's Name/Relationship (7  |  |   | ng Address (Street a                          |  |                                     |                                      |   |                    |
| and ealth n 27   |                 | Paul M. Watkins  |  |   | Fendall                                       |  |                                     |                                      |   |                    |
| of H<br>of H   |                 | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐                            | Removal from State   | <ol> <li>Place of Dispo<br/>cemetery, crei</li> </ol> | sition (Name of matory or other plac          | e)                                       | Date                                | 20c. Location -                      | City or Town, Stat                                      | te                 |
| Pages<br>ment of<br>ant: If its<br>jury or o   |                 | 4 Donation 5 ☐ Other (Specify  | ) H  |   | Mem. Park                                     |  | h 29, 20                            |                                      | ndover, l   |                    |
| permit<br>Depart<br>Import<br>any in   |                 | 21. Signature of Funeral Service Licen   | Donasti  |   | 2. Name and Addres                            |  |                                     |                                      |   |                    |
| A NE   |                 | 23a. Part1. Fnl. r the disease, or comp  | plications that cause the de   | eath. Do not ent                                      | er the mode of dyin                           | g, such as cardiac                       | or respiratory ar                   | rest,                                | Approx  | imate<br>I Between |
| Physician  |                 | Immediate Cause (Final disease or condition  | Pneumonia  |   |   |  |                                     |                                      |   | and Death          |
| /Medical   |                 | resulting in death)  | a<br>Due to (or as a cons  |   |   |  |                                     |                                      |   |                    |
| Examiner   |                 |  | b. =   |   |   |  |                                     |                                      |   |                    |
| T CENT   | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a cons   | sequence of):   |   |  |                                     |                                      |   |                    |
| nd   | Examiner        | that initiated events  | c  |   |   |  |                                     |                                      | 771   |                    |
|  |                 | resulting in death) Last   | Due to (or as a cons   | sequence of):   |   |  |                                     |                                      |   |                    |
| icate be executed<br>physician and<br>the burial-transit   | dical           |  | d  |   |   |  |                                     |                                      |   |                    |
| entific<br>ing p   | Mec             | IF FEMALE:   |  |   |   |  |                                     | 1                                    |   |                    |
| The law requires that the death certificate has been signed by the attending age 2 should be detached for use as | by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown       | 23c. If yes, outcome pf pre-<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time of<br>9 □ Unknown | etal death 3 [  | Ectopic pregnancy Other (specify)             |  |                                     | 23d. Date<br>Mor                     | e of delivery<br>nth Day                                | Year               |
| s that<br>ned b  | Z V             | Part II. Other significant conditions of   | ontributing to death but not i   | resulting in the u                                    | nderlying cause give                          | en in Part I.                            | 23e. Did to                         | obacco use contr                     | ribute to the cause                                     | of death?          |
| w requires<br>been sign<br>should be   | g<br>p          | Huntington's Di  | sease  |   |   |  | 1 🗆 ነ                               | res 2□ No                            | 3 ☐ Probably 2  | Unknown            |
| s bee  | Completed       |  |  |   |   |  | 24a. Was                            |                                      | Were autopsy findi                                      | ings available     |
| The lay<br>te has<br>age 2   | mc.             |  |  |   |   |  |                                     | rmed? p                              | orior to completion death?                              | of cause of        |
| sician: The la<br>certificate ha<br>irector, page 2  |                 | 25. Was case referred to medical   |  |   |   | 26. Place of Dea                         |                                     |                                      | I ☐ Yes 2 ☐ No  |                    |
| ysicia<br>s cer<br>direct  | To Be           | examiner?  | Hospital: 1 ☐ Inpatient 2  | ER/Outpatier  | nt 3 DOA Othe                                 | ar:                                      |                                     | tence 6 □Othe                        | er (Specify)  |                    |
| g Phy<br>er thi  | اۃ              | 27. Manner of Death  | 28a. Date of Injury  | 28b. Time of  |   |  |                                     | now injury occurr                    |   |                    |
| ndin<br>tth.<br>r: Aft   | <u>ē</u>        | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                | (Month, Day Year   | ) Injury  |   | Yes 2 □ No                               |                                     |                                      |   |                    |
| Atte   | ific            | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of injury - A<br>building, etc. (Spe  | t home, farm, str                                     | eet, factory, office                          |  | 28f. Location (S<br>City or Ton     | Street and Number                    | er or Rural Route                                       | Number,            |
| al Oir   | Certification:  | 4   Normoide   | building, etc. (Spe  | scily)  |   |  | City of You                         | m, State)                            |   |                    |
|  | Medical (       | 29a. Certifier (Check only one)  | ysiclan: To the best of my liner: On the basis of exam and manner stated.                      | knowledge, deat<br>lination and/or in                 | h occurred at the tin<br>vestigation, in my o | ne, date and place<br>pinion, death occu | , and due to the treed at the time, | cause(s) and ma<br>date and place, a | nner as stated.<br>and due to the cau                   | use(s)             |
| To the To  | Ž               | 29b. Signature and title of certifier  | ) ()   | 1   | 29c. License                                  | number                                   |                                     | 29d. Date signed                     | d (Month, Day, Yea                                      | ar)                |
|  |                 | 1.0 Al   | Do- 1  | U   | D5  | 52261                                    |                                     | March                                | 18, 200   | 8                  |
|  |                 | 30. Name and address of person who   | completed cause of death (I  | tem 23a) (Type  | Print)  | MD 0007/                                 |                                     |                                      |   |                    |
|  |                 | Allen Segal 151  |  |   | spring,                                       | MD 208/4                                 |                                     |                                      |   |                    |
| Stat<br>Registra   |                 | 31. Date filed (Month, Day, Year) MAR 2 1 2008                                     | 32. Registrar's Signary  | gnature   |   |  |                                     |                                      |   |                    |
|  |                 |  |  |   |   |  |                                     |                                      |   |                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 1230 РМ Raymond Birney Walstrum April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 300 Melbourne Boulevard E1kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Yrs. 216-56-9024 OCT 31, 1950 Maryland 57 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 328 Red Hill Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: Baltimore, Maryland 21215-0036 ۵ 3 ☐ Widowed 4 🕅 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Residential Elementary/Secondary (0-12) College (1-4or 5+) Finisher Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhoda Birney Nelson James Walstrum, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Joan Lipford/Sister 440 Muddy Lane, Elkton, MD 21921 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 2008

22. Name and Address of Facility
Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, MD 1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Cherry Hill, MD 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9∏Unknown 9 Unknown cate has been signed I, page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an autopsy performe 1☐ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 2 No Hospital: 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA Other (Specify) Certification: To funeral 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed Month, Day, Year) 29b. Signatuj 30. Name and address of serson who completed cause of death (Item 23 Ovia 2. Registrar's Signature

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

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**ORIGINAL** 

DHMH 17 Rev 1/2001

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Eleanor Ayers March 13, 2008 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 7, 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🕅 F 81 545-38-7011 1926 Director Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh MD 1 ☐ Yes 2 ☑ No Anne Arundel Director Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 3 ury or other traumatic event, the Medical Examiner must be n 703 Seagrove Road 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 N Married 1 ☐ Yes 2 No Specify. Specify: white Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleanor Marguerite Boorman Lloyd Fenton Parker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Ayers/spouse 703 Seagrove Road Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign ture Funeral Service State Anatomy Board 655 W. Baltimore Street 222 Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No No 3 ☐ Probably Completed Be

**Physician** /Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

show

The law requires that the death or riflicate be executed sician and burial-trans physician ng as attend r uSe signed by the a been si page 2 s certificate Physician: director funeral After the Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

|  |                              |  |                                       |                                     |       |     |                               |               | - 10  | ,   | 1          |            |                                  |
|--|------------------------------|--|---------------------------------------|-------------------------------------|-------|-----|-------------------------------|---------------|---|---|------------|------------|----------------------------------|
|  |                              |  |                                       |                                     |       |     |                               | <del></del> - |   | 24a. Was an autopsy performed? 1□ Yes 2□ No |            | completion | lings available<br>n of cause of |
| 25. Was case refer                                       | red to medical               |  |                                       | 26. Place of Death (Check only one) |       |     |                               |               |   |   |            |            |                                  |
| examiner?<br>1 ☐ Yes 2                                   | Ν̈́ο                         | Hospita  | l:<br>1 ☐ Inpatient 2 ☐               | ER/Outpatient                       | 3 🗆 1 | DOA | Other: 4                      | □ Nursing H   | ome   | 5 ☐ Residence 6                             | Other (Spe | cify)      | sige House                       |
| 27. Manner of Deat<br>Natural<br>2 \( \text{Accident} \) | 5 ☐ Pending investigation    |  | . Date of Injury<br>(Month, Day Year) | 28b. Time of<br>Injury              | М     |     | Injury at<br>Work?<br>1 ∐ Yes | 2 □ No        | 2 <b>8</b> d  | . Describe how injury                       |            |            |                                  |
| 3 ☐ Suicide<br>4 ☐ Homicide                              | 6 Could not be<br>determined | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |                                       |                                     |       |     |                               | 2 <b>8</b> f. | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |            |            |                                  |
| 29a. Certifier<br>(Check only                            |                              |  | To the best of my kn                  |                                     |       |     |                               |               |   |   |            |            | use(s)                           |

29c. License number

State

Certification: To

Medical

29b. Signature and title of certifier

Registrar

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and manner stated

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |  |   | For State  | State o  | of Marylar         |                                  | artment o                      |                               |                                  | Mental Hy   |               | 000                                 | 11600                           |  |
|--|--|---|--|--|--------------------|----------------------------------|--------------------------------|-------------------------------|----------------------------------|---|---------------|-------------------------------------|---------------------------------|--|
|  |  | -   | Registrar  1. Decedent's Name (First, Middle, L                                      | uncate   | or De              | alli                             | 2. Date of De                  |                               | ath 3. Time of Death             |   |               |                                     |                                 |  |
|  | Physici<br>/Medi   |   | Lisa M. Adkins   |  |                    |                                  | Month                          | Day                           | 2008                             | 0955 M  |               |                                     |                                 |  |
|  | Examin   | ner 4a Facility Name (If not institution, give street and number) 4b. City, Toylo, or Location of Death 4c. County of Dea   |  |  |                    |                                  |                                |                               |                                  |   | unty of Death |                                     |                                 |  |
|  |  |   | Keninsula Kegiona  |  | alsi               | bury                             | ,                              | Wicomico                      |                                  |   |               |                                     |                                 |  |
|  | Funeral<br>Director  |   | 221-48-9432  | Sex<br>1□M 2∏ F  | 7. Age (In yrs. 4] | If Under 1 Months                |                                | Under 24 Hrs.<br>ours Min.    |                                  | 8. Date of Birth<br>(Month, Day, Year)<br>June 28, 1966                         |               | lace (State or Foreign<br>atry) unk |                                 |  |
|  | and w  |   | Usual Residence of Decedent  10a. State 10b. County                                  |  | 1. 10c. Ci         | ity, Town or Lo                  | cation                         |                               |                                  |   |               | 1                                   | 0d. Inside City Limits          |  |
|  | Maryl<br>-f sho  | tor   | DE   |  | unk                | Delmar                           |                                |                               |                                  |   |               |                                     | 1 □Yes 2√ No                    |  |
|  | or 28a   | irec  | 10e. Street and Number   |  | l l                |                                  | 10f. Zip Co                    | ode                           |                                  |   | 10g. Citizer  | of What Cour                        | ntry?                           |  |
|  | 23a c  | Funeral Director  | 10640 Allens Mil   | 1 Road   |                    |                                  |                                |                               | 940                              |   |               | USA                                 |                                 |  |
|  | er deg   | nne   | 11. Marital Status unk   | Armed Fo   |                    | J.S. 13.                         | Was Deceder<br>f Yes, specify  | nt of Hispar<br>Cuban, M      | nic Origin? (S<br>lexican, Puert | pecify Yes or No<br>o Rican, etc.)  | - 14.         | Race - Americ<br>Black, White,      |                                 |  |
| 336                                      | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>disal Examiner must be notified at   |   | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                               | 1 ☐ Yes<br>If Yes, Gi<br>Year or □   | ive                |                                  | i⊡Yes 2 <mark>X</mark>         | No Sp                         | pecify:                          |   | Sp            | pecify: whi                         | te                              |  |
| 5-0036                                   | 72 hou<br>natura<br>lical E  | Completed by  | 15. Decedent's E<br>(Specify only highest g  | <br>Education<br>rade completed)   |                    | 16a. Deced                       | tent's Usual C                 | Occupation                    | n<br>g most of wor               | king unk  | 16b. Kind     | of Business/Inc                     | dustry unk                      |  |
| 2121                                     | ithin ne.  | m ple   | Elementary/Secondary (0-12)  | College (  |                    | life. I                          | OO NOT use                     | retired)                      | g most of wor                    | Kii ig  |               |                                     |                                 |  |
| d 2.                                     | filed w<br>Hygie<br>ther t   | S   | unk 17. Father's Name (First, Middle, Las  | unk  |                    |                                  | unl                            | - 18.                         | Mother's Nan                     | ne (First, Middle,  | Maiden Su     | rname)                              |                                 |  |
| Maryland                                 | ld be<br>ental<br>ked o  | To Be   | ( , , , , , , , , , , , , , , , , , , ,  | -7   |                    |                                  | um                             |                               |                                  | Hasting   |               | ,,,,,,,                             |                                 |  |
| ary                                      | shou<br>and M<br>s mar   | -   | 19a. Informant's Name/Relationship   |  |                    |                                  |                                |                               | Number or Ru                     | ırai Route Numbi  | er, City or T |                                     | Code)                           |  |
|  | and 2<br>ealth a<br>n 27 is  |   | Penninsula Regi  | onal Ho  | -                  |                                  |                                |                               | Stree                            | t Salisb  | ury,          | MD 218                              | 301                             |  |
| Baltimore,                               | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3   4 ☐ Donation 5 ☒ Other (Spec | □Removal from  |                    | Place of Dispo<br>cemetery, crer | sition (Name<br>natory or othe | of<br>er place)               | ;<br>1<br>1<br>2<br>4            | Date  | 20c. Locat    | ion - City or To                    | own, State                      |  |
| Balti                                    | permit. Departr Importa any inju   |   | 21. Signature of Funeral Socioe Lice<br>Ronald S                                     |  | irecto             | _                                |                                |                               | y Board                          | 1 655 W.  | Balt          | imore S                             | treet                           |  |
|  |  |   | 23a. Part1 Enter the dise x e, or or shoc or heart failure. List only                | mplications that   | caused the dea     |                                  |                                |                               |                                  |   | rrest,        |                                     | Approximate<br>Interval Between |  |
|  | Physician  | П   | Immediate Cause (Final disease or condition  |  |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
| L  | Examiner   | Н   | resulting in death)  | Due to   | (or as a consec    | quence of):                      |                                |                               |                                  |   |               |                                     |                                 |  |
|  |  | ē   | Sequentially list conditions, if any, leading to immediate                           | b  |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
|  | outed<br>id<br>ansit   |   |  |  |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
| 30,                                      | icate be executed<br>physician and<br>the burial-transit   | Exc   | resulting in death) Last   | Due to   | (or as a consec    | quence of):                      |                                |                               |                                  |   |               |                                     |                                 |  |
| 8760,                                    | cate b<br>physic<br>the b  | dical   |  | d  |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
| Box 6                                    | certifi<br>nding<br>use as   | /Me   | IF FEMALE:   | 23c. If yes, ou  | tcome pf pregn     | ancy                             |                                |                               |                                  |   | 230           | I. Date of delive                   | en.                             |  |
|  | death<br>e atter<br>d for u  | 25b. Was decedent pleghalm   1 Live birth   2 Fetal death   3 Ectopic pregnancy   Month   Day   1   Vas   2   TNo   4   Pregnant at time of death   5   Other (specify)   Month   Day   |  |  |                    |                                  |                                |                               |                                  | ,   |               |                                     |                                 |  |
| P.0                                      | at the<br>by th  | hys   | 9 ☐ Unknown  | 9□Unkn   |                    |                                  |                                |                               |                                  | _   |               |                                     |                                 |  |
| s Eq q q q q q q q q q q q q q q q q q q |  |   |  |  |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
| ၀၁                                       | aw requir<br>as been si<br>2 should  | Temp   Temp |  |  |                    |                                  |                                |                               |                                  | psy findings available  |               |                                     |                                 |  |
| Ä  |  | Wo.   |  |  |                    |                                  |                                |                               |                                  | autor<br>perfo<br>1 Yes   | rmed?         | death?<br>1 ☐ Yes                   |                                 |  |
| Vital                                    | cian:<br>sertific  | 25. Was case referred to medical examiner?  |  |  |                    |                                  |                                |                               |                                  |   | ne)           |                                     |                                 |  |
| o  | Physician:<br>this certific<br>ral director,   | 은   | 1 Yes 2 No   | Hospital: 1-Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred |                    |                                  |                                |                               |                                  |   |               |                                     | y)                              |  |
| O  | iding Phy<br>h.<br>After thi<br>funeral o  | tion  | 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation                                   | (Mor   | nth, Day Year)     | Injury                           | м   280                        | Injury at<br>Work?<br>1 ☐ Yes | 2 □ No                           | 28d. Describe how injury occurred   |               |                                     |                                 |  |
| Division or                              | or Attend<br>after death.<br>Director: /<br>in by the f  | Certification:  | 3 Suicide 6 Could not 4 Homicide determined  | e 29a Place of injury. At home form street factory office  |                    |                                  |                                |                               |                                  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |               |                                     |                                 |  |
| _  | To the Hospital or Attending Phys<br>within 24 hours after death.  To the Funeral Director: After this<br>completely filled in by the funeral di   | Medical Co  | 29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa                     | (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)               |                    |                                  |                                |                               |                                  |   |               |                                     |                                 |  |
|  | 29b. Signature and title of certifier 29c. License number  |   |  |  |                    |                                  |                                |                               |                                  | 29d. Date s   | igned (Month, | Day, Year)                          |                                 |  |
|  |  |   | * K Clero  |  |                    |                                  |                                |                               | 16197                            |   | 3/3           | 3/31/08                             |                                 |  |
|  |  |   | 30. Name and address of person who   |  |                    |                                  | Print)                         |                               |                                  | ) /   |               |                                     |                                 |  |
|  |  |   | 31. Date filed (Month, Day, Year)  |  | Registrar's Sign   | Sali                             | on M                           | 15 4                          | 80) M                            | obert C   | OKER          | M.D.                                |                                 |  |
|  | Sta<br>Registr   |   | APR 1 0 20   | 008  | Registrar's Sign   | K Apr                            | West !                         |                               |                                  |   |               |                                     |                                 |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician**  $P^{M}$ William Marvin Athey 04/07/2008 3:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6620 Washington Blvd., Unit 44 Elkridge Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F 218-24-6350 76 5/27/1931 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Modical Evantine must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Director MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6620 Washington Blvd., Unit 44 Funeral 21075 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>8</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 K&G Instrument Co Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester Athey Louise Penn ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Martha Athey / Wife 6620 Washington Blvd., Unit 44, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory 04/09/2008 | Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD M01378 23a, Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage /Medical Due to (or as a consequence of Examiner Congestive Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Obstuctive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertens autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖼 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4-9-08 38747 ms ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

ORIGINAL

Baltimore, Maryland

Suite 107

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registamend #2&29d Per Phy G878 4/10 Detificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 3. Time of Death Month **Physician** Justas Buivys APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTI MORE STAUNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1**X** M 2□ F 220-30-6104 Director 88 12/13/1919 Lithuania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 YNo Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 624 North Bend Road 21229 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel may injury or other traumatic event, the Medical Examines ency. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Justinas Buivys Ona Zilinskaite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramune Buivys / Daughter 236 N. Beaumont Avenue Catonsville, MD 21228 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 04/08/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229 Na 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY 5 DAY'S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 page 2 1∐ Yes Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No after death 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely f (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Monthy Day, Year) hut Jaws

State Registrar 31. Date filed (Month, Day, Year)

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900 CATON
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

AVE BALTIMORE MD-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nonth Day Year **Physician** 12PM James Briggs HOG 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore HU 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number e (In yrs. last birthday) **Funeral** Min 1 X M 2 □ F 189-54-4487 Director Jan 6**,** 1973 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examlner must be notified at MD 1√ Yes 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 501 W. Franklin Street 21201 IISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: black <u>2</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Medical un unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Linden Avenue Baltimore, MD Maryland General Hospital Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature Ronal Di Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (Dowie) Lntas /Medical Due to (or as a consequence of): Examiner ongestive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy ĮQ. in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 Yes 2 No 3 Probably 4 ✓ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 100 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ala

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31. Date filed (Month, Day, Year)

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m.D

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1009 PRIL /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number, Examiner DURNIE ANNE 8. Date of Birth Mar 24, 1936 Under 24 Hrs. 9. Birthplace Country) Under 7. Age (In yrs. last birthday) 72 Yrs. Social Security Number **Funeral** Hours Min. Months Davs Ohio 1 ☐ M 2 💢 F 213-32-5309 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2▼ No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA 8224 Baltimore Annapolis Blvd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No 21215-0036 Specify Specify: white Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. waitress food service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 1 and 2 should be Health and Mental John Steven Szabo Anna Kovac 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Cathy Redmond/daughter 1242 Guildford Road Glen Burnie, MD Baltimore, Important: If item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euheral Sympton tensee Wade Baltimore. MD 21201 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner KULWOV cuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 ☐ Other (specify) the 8 9 Unknown 9 Unknown β 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No certificate has page 2 2 No 1 TYes MONOR Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2**∏**ÛNo 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ After this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred Certification: 27. Manner of Death 28h. Time of 28c. Injury at Work? or Attending 1 ⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier 0 cause of death (Item 23a) (Type, Print) 30. Name and a free s of person who completed Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

1 0 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:59 AM 2003 tori Josephine M. Bergerson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Bultimore Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 😿 F 85 Mar 22, England Director 217-26-1287 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐Yes 2 No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or pe with ms 23a must b 3320 Ripple Road 21244 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours efter death Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or items 23 any Injury or other traumetic event, the Medical Examiner must once. 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick George Baker Alice Elsie Buckingham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lance D. Bergerson/son 302 Sophia Court Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signat 1222 Baltimore, 21201 MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): 30 years Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examines attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident (Month, Day Year, Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After death. ours fter death. within 24 hours

To the Funeral I

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D

28f. Location (Street and Number or Rural Route Number, City or Town, State)

W. Be lupcleve Ave, Betmanno

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

3 ☐ Suicide

4 Homicide

HOSPita

31. Date filed (Month Pay Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:50 P M Paul Joseph Brown, Sr. Apr 3, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** Timonium Stella Maris (Cardinal Shehan Center) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. Director 88 214-12-7658 Mar 11, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21228 2021 Old Frederick Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after salth and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes ZENo Maryland 21215-0036 White <u>م</u> Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Bread Delivery** Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Cecelia O'Neill **Carl Thomas Brown** ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is 11803 Shebourne Dr. Timonium, MD 21093 Joyce Brown Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important; If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Department of Apr 07, 2008 Sunshine, MD 4 Donation 5 Dother (Specify) Patuxent Cemetery of Mt. 21. Signature of Funeral 3e vice Lonsee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunsecuring off Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2379 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably een 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has perform Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Tes 2 10 1 🔲 Inpatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir ဥ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending Injury investigation Μ 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and le of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le

DHMH 17 Rev 1/2001

State Registrar EDDIE NAKHUDA, M.D.

PAUL

TIMONIUM

21093

MD

2300 DULANEY VALLEY ROAD

32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BUCKSON **Physician** 1:12 2008 /Medical City, Town, or Location of Death 4c. County of Deatl Facility Name (If not institution, give street and number) Examiner timore VANRedicAL DALT MORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, You 11 28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8 28 **Funeral** Days 1 X M 2 □ F 79 250-40-3325 SC Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County show items 23a or 28a-f shov ner must be notified at 1 TyYes 2 □ No N/A Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 1653 N. Milton Avenue 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ★★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: þ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) steel worker N/A 12th Bethlehem Steel 12 should be filed w h and Mental Hygier 7 Is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev Wade Buckson Rachel Kinsler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1653 N. Milton Avenue Baltimore, MD 21213 Elvera Buckson-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA 4/12/08 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MARCH FUNERAL HOME-EAST ladre Warre Avenue Baltimore, MD 21202 1101 E. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 years **Physician** Multiple Myeloma
Due to (or as I consequence of): disease or conditior resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1□ Yes 2 No 2□ No 1 TYes ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 ☐ Homicide within 24 hours a To the Funeral I Medical

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician;

the

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435 W17471 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONORTH GREENE STREET BACKIMORE, MD 21201 Wermine Ashlev

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death PM **Physician** ROWN 2008 eor 96 /Medical County of Death 4b. Gity, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner BACTIMORE BALTIMORE HOSPITAL JAMAR 17AN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show r 28a-f show notified at 1 XYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 1219 Winston Avenue 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? X 2 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, r than "natural", or items the Medical Examiner me Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1. Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Produce Manager ACME Supermarket 12th N/A other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event Be Clarence Α. Brown Sr. Rosie Ε. Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roberta Louise Brown-wife 1219 Winston Avenue Baltimore, MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State Garrison Forest VA 4/9/2008 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee rich W. march 1101 E. North Avenue Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SPIRATORY **Physician** /Medical Due to (or as a consequence of) **Examiner** CAN NG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No ed by the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe LSOPHAGEAL 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To s after death.

I Director: After this of in by the funeral d 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🔀 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after To the Funeral Discompletely filled in

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. KOMSUS, M.D. 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239.2995

32. Registrar's Signature

YSICIAN

Registrar

D0051024

29d. Date signed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖓 🔒 🤮 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** her 2008 FRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5686 Stevens Forest Road #26 Columbia Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 Ohio 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, 5. Social Security Number Funeral Year Days 215.52-81 NOV Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Experimental barrottified at HOWARD MP 1 □Yes 2 No OLUMBIA Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21045 5686 Stevens Forest Road Unit 26 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Tayes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Contract Administrator Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marshall Willard Brain Dorothy Hicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Brain (Son) 6900 Lake Drive Apt H Dublin, CA 94568 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4-8-2008 Catonsville, MD Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licensee MOIDST Inc. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR MINUTES **Physician** /Medical Due to (or as a consequence of): Examiner ARDIOMYOPATH Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed CORONARY and Due to (or as a consequence of) burial-Box 68760. aftending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. PARNES, M.D. 11085 L.

State Registrar Year).

32. Paristrar's Signature

LITTLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year BURCH 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) **Funeral** Director .10, 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show must be notified at 1. Yes 2 No **Funeral Director** Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE NIGHT CLUB 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surnam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final IMMUNE DEFILIENCY **Physician** ACQVICED disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the dath certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has t irector, page 2 s 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2**1** No Hospital: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 6 MOther (Specify) s after death.

I Director: After this of in by the funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-6.00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. But Aw ST # 305 BACTMONE MS 21201 K21 gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| March 30, 2008   2:12  | Physician  | 1. Decedent's Name (First, Middle, La                                  | Month   | 2. Date of Death Month Day Year 3. Time of Death |  |                      |  |                       |             |                                 |  |  |
|--|--|--|---|--|--|----------------------|--|-----------------------|-------------|---------------------------------|--|--|
| Mashington Adventise   Rospital   Takoma Park   Rospital   Takoma Park   Rospital   Ro   |  |  |   | March  | March 30, 2008 2:12 PM                                 |                      |  |                       |             |                                 |  |  |
| Social Security Furcher    Security   Control    Examiner   |  | ,   |  |  |                      | eath                                     |                       |             |                                 |  |  |
| 382—184—6815   100 County   100 | Funeral  |  |   |  | If Under 1 Year  | If Under 24 I        |  | rth                   | 9. Birth    | place (State or Forei           |  |  |
| 10   State   10   County   Prince George's   College Park   10   To 20 Code   10     |  | 382-18-4815  | 1□M 2\ F 85   | Yrs.   | Months Days  | Hours N              | lin.   (Month, Da<br>  Sept 2            | 23, Year)<br>23, 1922 | Scot        |                                 |  |  |
| 17. Father's Name (First, Middle, Last)   18. Mailing Address (Street and Number or Plant Florated I)   18. Mailing Address (Street and Number or Plant Route Number)   18. Mailing Address (Street and Number or Plant Route Number)   18. Mailing Address (Street and Number)   18. Ma   | 2  |  | 10c City  | / Town or Lo                                     | cation   |                      |  |                       |             | 10d Incido City Limit           |  |  |
| 17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mastern Surrane)   18. Mother's Name (First, Middle, Mastern   | f sho  | ,  |   |  |  |                      |  |                       |             | 1 ☐ Yes 2√∑N                    |  |  |
| 17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mailton Summe)   18. Informatic Name (First, Middle, Mailton Summe   | 28a-<br>notifi   | 10e. Street and Number   | 00180   | 1080 1   |  |                      |  | 10g. Citizen of       | What Cou    |                                 |  |  |
| 17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mastern Surrane)   18. Mother's Name (First, Middle, Mastern   | st be  | 9014 Rhode Islan   | d Avenue #221   |  | 2074   | 0                    |  | U                     | SA          |                                 |  |  |
| 17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mastern Surrane)   18. Mother's Name (First, Middle, Mastern   | er mu  | 11. Marital Status   | 12. Was Decedent Ever in U.<br>Armed Forces?                | S. 13. V   | Vas Decedent of H<br>f Yes, specify Cuba               | ispanic Origin's     | (Specify Yes or No<br>uerto Rican, etc.) | o- 14. Ra<br>Bla      |             |                                 |  |  |
| 18. Maling Address (Street and Ambero of Plants Middle, Mastern Surraine)   18. Maling Address (Street and Ambero of Plants Revised Deposition)   18. Maling Address (Street and Ambero of Plants Revised Plants P   | all all y  | 1 Never Married 2 Married  | If Yes, Give  |  |  |                      | ,  |                       |             |                                 |  |  |
| Solidan   Interval   Interv   | tural al Ex  | 15 Decedent's F  |   | 16a Deced  | lent's Usual Occun                                     | ation                |  |                       |             |                                 |  |  |
| Sicilar   Sici   | n "na<br>Medic<br>plet                                       | (Specify only highest gr   | ade completed)  | (Give<br>life. L                                 | kind of work done of NOT use retired                   | during most of<br>d) | working                                  | 100. Mild of E        | 03111033/11 | idustry                         |  |  |
| Part I. Inter the disore   Part I. Story to complete the service of the service   | ar tha   | 12   |   | s  | ecretary   |                      |  |                       |             |                                 |  |  |
| Part   Inter the diser   Part   Inter the diser   Part   Interest   Interes   | d other  | 17. Father's Name (First, Middle, Las.                                 |   |  |  |                      | •  |                       | ,           |                                 |  |  |
| Sicilar   Sici   | arke<br>artic  |  |   |  |  |                      |  |                       |             |                                 |  |  |
| Part I. Inter the disore   Part I. Story to complete the service of the service   | 7 is m<br>traum  |  |   | 1  |  |                      |  |                       |             | ,                               |  |  |
| Part I. Iner the disease. Soft licates that caused the death. Do not enfer the mode of dying, such as cardiace or respiratory arrest, interval Barrier Market and the cause of each line.  Part I. Iner the disease. Final process and the cause of each line.  Part I. Iner the disease. Final process and the cause of each line.  Part II. Other sale of the cause of each line.  Due to (or as a consequence of):  Due to  | em 2   |  |   |  |  | lace n               |  |                       |             |                                 |  |  |
| Solidan   Interval   Interv   | y or or  | 1 ☐ Burial 2 ☐ Cremation 3 ☐   | Removal from State  | emetery, cren                                    | natory or other plac                                   | :e)                  |  |                       | o, o        | om, out                         |  |  |
| Sician Ball Limited   Sician Stroke   Sician   | injur<br>e.  |  | Y   |  |  |                      |  |                       |             |                                 |  |  |
| Sician   Section   Secti   | any pro-   | Ronald   | wade, Myrector  | S  | tate Ana<br>altimore                                   | tomy Bo<br>MD 2      |  | 7. Balti              | more        | Street                          |  |  |
| Immediate Cable (Final Date of Core as a consequence of):   PAraesopha geal HERNIA   Due to (or as a consequence of):   PAraesopha geal HERNIA   Due to (or as a consequence of):   PAraesopha geal HERNIA   Due to (or as a consequence of):   Due to (or as a con   |  | Zda. Part1. Inter the dise / e, / conshock, / heart failure. List only | plical end that caused the death<br>one cause on each line. | n. Do not ente                                   | er the mode of dyin                                    | ng, such as car      | diac or respiratory a                    | arrest,               |             | Approximate<br>Interval Between |  |  |
| Due to (or as a consequence of):   | sician   | Immediate Ca (Final disease or condition                               | STra  | ngui   | lateo  | 575                  | MACH                                     | +                     |             | Onset and Death                 |  |  |
| Due to (or as a consequence of):   | - C - C - C - C - C - C - C - C - C - C                      | resulting in death)  | Due to (or as a consequ                                     | uence of):                                       | PAraes   | opha                 | geal H                                   | ERNI                  | 4)          |                                 |  |  |
| Due to (or as a consequence of):    Due to (or as a consequence of):   | 400  | Sequentially list conditions,  | b   |  |  |                      |  |                       | -           |                                 |  |  |
| Template    | Due to (or as a consequence of):  Lause, (Disease or injury) |  |   |  |  |                      |  |                       |             |                                 |  |  |
| FEMALE: 23b. Was decedent pregnant in the past 12 months 1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. If yes, outcome pf pregnancy   1   Yes 2   Dithorown   23c. Dithor (specify)   23c. Dithorown   2   | an and<br>rial-tra   | resulting in death) Last   |   | uence of):                                       | -  |                      |  |                       |             |                                 |  |  |
| Second of the past 12 months   1   1   1   1   1   1   1   1   1   | he bu  |  | ▲d  |  |  |                      | <del></del>                              |                       |             |                                 |  |  |
| Second   S   | ing ple as t   | IF FEMALE:   |   |  |  |                      |  |                       |             |                                 |  |  |
| The state of the s | for us   | 23b. Was decedent pregnant   | 1 ☐Live birth 2 ☐ Feta                                      | Ideath 3□  |  | ,                    |  | 1                     |             |                                 |  |  |
| Second   S   | ched ched  |  |   | eatn 5∟  | Otner (specify)  |                      |  |                       |             |                                 |  |  |
| Second   S   | y Ph   | Part II. Other significant conditions                                  | contributing to death but not resu                          | 23e. Did   | 23e. Did tobacco use contribute to the cause of death? |                      |  |                       |             |                                 |  |  |
| The state of the s | and be   |  |   |  |  |                      | _ 10                                     | Yes 2□ No             | 3∏ Pro      | bably 4 □Unknow                 |  |  |
| 25. Was case referred to medical examiner?   | 2 sho  |  |   |  |  |                      |  |                       | Were aut    | opsy findings availab           |  |  |
| 25. Was case referred to medical examiner?    1  | page page  |  |   | -  |  |                      | perf                                     | ormed?                | death?      |                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | ctor, I  |  |   |  |  |                      |  |                       |             |                                 |  |  |
| 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print)  | this of  | 1   Yes 2   No   | idence 6 □Ot  | ner (Speci                                       | fy)  |                      |  |                       |             |                                 |  |  |
| 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print)  | After funera   |  |   |  |  |                      |  |                       |             |                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | the y the  | 3 Suicide 6 Could not b  | e 390 Place of injury. At he                                | me farm str                                      | 1  | Yes 2∐No             | 28f Location (                           | Stroot and Num        | har ar Pur  | al Pouto Number                 |  |  |
| Theory Coww. D057785 03/31/68 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print)  | Directif   | 4 Homicide determined  | building, etc. (Specify                                     | ()   | set, factory, office                                   |                      | City or To                               | wn, State)            | der or mur  | ai noute Number,                |  |  |
| 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print)  | y fillec   | 29a. Certifier 1 Certifying P  | hysician: To the best of my kno                             | wledge, death                                    | occurred at the tir                                    | ne, date and p       | lace, and due to the                     | cause(s) and m        | anner as    | stated.                         |  |  |
| 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print)  | he Fu<br>pletel  | (Check only 2 Medical Exa  | miner: On the basis of examina                              | tion and/or inv                                  | vestigation, in my o                                   | pinion, death o      | occurred at the time                     | , date and place      | and due     | to the cause(s)                 |  |  |
|  | To t   | 29b. Signature and title of certifier                                  | 0 00  | \  | 29c. License   | e number             | 200                                      | 29d. Date signe       | ed (Month,  | Day, Year)                      |  |  |
|  |  | Heory  | own IVW   | )  | 126  | 15+                  | + 05                                     | 03/                   | 31          | 108                             |  |  |
|  |  |  | completed cause of death (Item                              | 23a) (Type, I                                    | Print)   | 1001                 | 1.                                       | 2 (                   | 1           | + + 11                          |  |  |
| State 31. Date filed (Month) Day, Year)  Begistrar  Begistrar  Begistrar   | Chata  | 31. Date filed (Month) Day, Year)                                      | , Ohya  | ture   | 1D, U  | <u>1450</u>          | ingto                                    | N UC                  | xve         | N1151 16.                       |  |  |

DHMH 17 Rev 1/2001

| /  | M  | ar        | been BeniTez   |  |   |                             |  |   |                      |                    |  |   |  |  |
|--|--|-----------|--|--|---|-----------------------------|--|---|----------------------|--------------------|--|---|--|--|
| 08-01737   |  |           |  | e or Print in Bl                         |   |                             |  |   | •                    | _                  |  |   |  |  |
| UNK UNK  |  |           | St.<br>1- For State  | ate of Maryland                          | •   |                             |  |   | tal Hygie            | ne                 | 201  | 08 1163                                   |  |  |
|  |  |           | Registrar  1. Decedent's Name (First, Middl                                    | -1                                       | Cer   | tificate (                  | of Deal  | n   | la Da                | Reg                | 3. No.   |   |  |  |
| Ph<br>Medical E  | ysicia<br>xamii  | 411/      | Deysi Marler   | •  |   |                             |  |   |                      | onth<br>bruary 29  |  | 3. Time of Death<br>1610 hrs              |  |  |
| - i-   |  |           | 4a. Facility Name (if not institution  |  |   |                             | 4b. City,  | Town, or Location                         |                      | bruary 2           | 4c. County of De                                     |   |  |  |
|  |  |           | Rt.#15 & Saint Anthor  | ny Road                                  |   |                             | Emm  | itsburg                                   |                      |                    | Frederick  |   |  |  |
| Fur  | neral  |           | 5. Social Security Number  | 6. Sex 7. Age                            | e (In yrs. I  | ast birthday)               |  |   |                      | ate of Birth       | (MM/DD/YYYY) 9.                                      | Birthplace (State or                      |  |  |
| Dire   | ctor   |           | 216-63-4853  | 1 M 2 X F                                | 26  | Y                           | rs. Mont   | ns Days Hours                             |                      | ec. 01             | 1981   | Courlity) Salvado:                        |  |  |
|  |  |           | Usual Residence of Decedent  |  |   |                             |  |   |                      |                    |  |   |  |  |
|  | w any  |           | 10a. State 10b. County   |  | 10c. City,  | Town or Loc                 | ation  |   |                      |                    |  | 10d. Inside City Limits 1 X Yes 2 No      |  |  |
| /land  | -f sho   | ġ         | MD Frede   | rick                                     | Fı  | cederi                      |  |   |                      | 120                |  |   |  |  |
| Man Man  | r 28a<br>ied at  | Director  | 10e. Street and Number   |  |   |                             | 10t. Zij   | Code                                      |                      | 10                 | 10g. Citizen of What Country?                        |   |  |  |
| iii th   | 23a o<br>notifi  |           | 1252 Danielle  | Fire in 11                               | 0 140 1   | _                           | 21703  | -in2 / Consilin                           |                      | El Salvador        |  |   |  |  |
| at ×   | items<br>ist be  | Funeral   |  | 12. Was Decedent<br>Armed Forces?        |   |                             |  | ent of Hispanic Ori<br>ify Cuban, Mexican |                      |                    | o- 14. Race - American Indian, Black,<br>White, etc. |   |  |  |
| ler de   | ", or  |           | 3 X Widowed 4 Div  | orced If Yes, Give Year                  | X No  | 1 🛚                         | Yes 2  | No specify:                               | salvad               | oran               | Specify: Wi  | nite                                      |  |  |
| ours a   | amin   | d by      | 15. Decedent's Education (Spe  | or Dates:<br>cify only highest grade com | pleted)   | 16a. Deced                  | ent's Usua   | Occupation (Give                          | kind of work do      |                    | 16b. Kind of Busine                                  |   |  |  |
| <b>5</b>   | n "nz  | e         | Elementary/Secondary (0-12)  | 5+)                                      | during  | most of wo                  | rking life. DO NOT   | use retired)                              |                      |                    |  |   |  |  |
| 5-0036<br>lled within 72<br>Hygiene.   | Medi   | ompleted  | 3rd  |  |   | Coo                         | ok   |   |                      |                    | Outback Restaurant                                   |   |  |  |
| 15-(<br>filed v<br>Hvgj  | d oth  | ပ၂        | 17. Father's Name (First, Middle,  | ·  |   |                             |  |   |                      |                    | aiden Surname)                                       |   |  |  |
| <b>2121</b><br>vuld be fi  | even   | o Be      | Miguel Angel   | bin (Type Print ).                       |   | 19h Mail                    | ing Addres   |   |                      |                    | nteros der, City or Town, S                          | e Benitez                                 |  |  |
| MD 2   |  |           |  |  |   |                             |  |   | erick Maryland 21703 |                    |  |   |  |  |
| e, <b>€</b><br>and 2   | item   |           | 20a. Method of Disposition   |  |   | Place of Disp               | osition (Na  | me of cemetery,                           | Date                 |                    | 20c. Location - Cit                                  |   |  |  |
| 10Fo   | other IT   | - [       | 1 X Burial 2 Cremation   | _  |   |                             |  | •   | 04-17-               | .ne                | Cahanas  | El Salvador                               |  |  |
| 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and  22. Name and  23. Place of Disposition (Nat crematory or other place Family Cemete  22. Name and  |  |           |  |  |   |                             | Address of Facilit   |   |                      | Tunana 1           | Home, Inc.   |   |  |  |
| <b>B</b> 50 Per Dec  |  | ļ         | Manda  | C. Baco                                  | an!   | 2036 3                      | 3447 1   | 4th St.                                   | N.W. W               | acon<br>Ashina     | gton DC 2  | nome, inc.                                |  |  |
| Physi  | cian   |           | 23a. Part I. Enter the disease, or failure. List only one cause                | complications that caused                | the death   | . Do not ente               | r the mode   | of dying, such as o                       | cardiac or respi     | iratory arre       | st, shock, or heart                                  | Approximate Interval<br>Between Onset and |  |  |
| /Med<br>≂xam   | -  | - 1       | Immediate Cause (Final disease   | D 1 11                                   | hvxia   |                             |  |   |                      |                    |  | Death                                     |  |  |
| Adii   | IIIICI   | - 1       | or condition resulting in death)   | Due to (or as a conse                    |   |                             |  |   |                      |                    |  |   |  |  |
|  |  | اير       | Sequentially list conditions, if any, leading to immediate                     | b<br>Due to (or as a conse               | auence o  | f):                         |  |   |                      |                    |  | -   |  |  |
|  |  | miner     | cause. Enter Underlying Cause<br>Disease or injury that initiated              | 6  | 17.   | 8                           |  |   |                      |                    |  |   |  |  |
| / 5  | usit   | Exar      | events resulting in death) Last  | Due to (or as a conse                    | equence o   | f):                         |  |   |                      |                    |  |   |  |  |
| V execute  | n and<br>- trar  |           | V UNDENDED   | d  | 27 20   |                             | MD . 0   | 70 / /1 / /00                             | 1                    |                    |  |   |  |  |
| o, e pe e  | ysician<br>burial  | edical    | X UNPENDED   | AMENDED 23a                              |   |                             | ME go  | /8 4/14/08                                | amh<br>————          |                    | Tax S  |   |  |  |
| Box 68760,   | ng ph<br>as the  | an/M      | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?             | 23c. If yes, outcor                      | ne of preg  |                             | Fetal death  | 3 Ectopi                                  | ic pregnancy         |                    | 23d. Date of del<br>Month                            | Day Year                                  |  |  |
| X 6  | tr use   | sicia     | 1 Yes 2 No 9 X Uni   | 4 Pregnant at                            | time of de  | eath 5                      | Other (Spe   | ecify)                                    |                      |                    |  |   |  |  |
| . <b>B</b>   | y the a  | 골         |  | 5 OHKHOWH                                |   |                             |  | i i- D                                    |                      | 22a Did tak        | and the contribut                                    | e to the cause of death?                  |  |  |
| P.O.   | has been signed by the attending physician and<br>2 should be detached for use as the burial - tra | b         | Part II. Other significant condit  | ions contributing to death               | i but not n   | esuling in th               | e underlyin  | g cause given in Pa                       | art I.               |                    |  | Probably 4 V Unknown                      |  |  |
| <b>15,</b>   | en sig<br>uld be   | ted       |  |  |   |                             |  |   | — <u>+</u>           | 24a. Was a         |  | e autopsy findings available              |  |  |
| Orc  | has be<br>2 sho  | Completed |  |  |   |                             |  |   | — l                  | autops             | y prior  | to completion of cause of                 |  |  |
| Rec<br>™   | certificate<br>ector, page   | 悥         |  |  |   |                             |  |   |                      | ✓ Yes 2            |  | Yes 2 No                                  |  |  |
| cian:  | his certificate  <br>director, page  | Be        | 25. Was case referred to medical examiner? 26. Place of Death (Check only one) |  |   |                             |  |   |                      |                    |  |   |  |  |
| f Vi<br>Physi  |  | 의         | 1 Yes 2 No<br>27. Manner of Death  |  | ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6 ✓ Other: Scer |                             |  |   |                      |                    |  |   |  |  |
| n or ding  | : Afte   | <u>ë</u>  | 1 Netweel  |  | I A D V o T N-  |                             |  | d. Describe how injury occurred           |                      |                    |  |   |  |  |
| Division of Vital Records    Second of Condition   |  |           |  |  |   | rnd 3:42p Subject assaulted |  |   |                      |                    |  | r Rural Route Number City                 |  |  |
| The standard of the standard o |  |           |  |  |   |                             | office building, etc.  28f. Location (Street and Number or Rural Route Number or Town, State) Wooded 1 ot @ intersect Rt.15 & St.Anthony Rd. Firmitsburg |   |                      |                    |  |   |  |  |
| - Hospit<br>4 hour   | Fumer<br>ely fill  |           | 29a. Certifier   | hysician: To the best of m               |   |                             | curred at th   | e time, date and nl.                      |                      |                    |  |   |  |  |
| thin 2.  | mplet  | Medical   | Conton only  | miner: On the basis of examiner stated.  |   | -                           |  |   |                      |                    |  |   |  |  |
| 29b. Signature and title of certifier 29c. License nur   |  |           |  |  |   | c. License number           |  |   | 29d. Date signed     | (Month, Day, Year) |  |   |  |  |
|  |  |           | Donna Mi   | lineati, mos.                            |   |                             |  | O.C.M.E.                                  |                      |                    | March 2, 200   | 8   |  |  |
| 00   | K )  | ŀ         | 30. Name and address of person   |  | eath (Item  | 1 23a)                      |  |   |                      |                    |  | <del></del>                               |  |  |

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day, Year)
APR 1 0

Donna M. Vincenti, MD Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

| 08-020 | 40     |
|--------|--------|
| Lamell | Barnes |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 11636 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Leme11 Omar Barnes Physician/ 2309 hrs March 12, 2008 Medical Examiner Lemel1 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2800 Block Denham Circle N 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Months Day: Hours Country) 5-23-1985 22 Director 218-08-2689 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County any 1 Yes 2 No Baltimore N/A items 23a or 28a-f show ust be notified at once. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number IJ SA 21225 Road 2902 Spellman 14. Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married Yes Black 9 Yes 2 X No specify: If Yes, Give Yaar 3 Widowed 4 Divorced 16b. Kind of Business/Industry "natural" à 16a. Decedent's Usual Occupation (Give kind of work done Unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) the Medical 21215-0036 Maintenance N/Allth grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tracy Allen Preston Barnes, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ MD 21225 Baltimore, MD 2902 Spellman Road Balto, Tracy Allen - Mother If item 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition
1 X Burial 2 Crem crematory or other place)
Zion Cemetery Cremation 3 Removal from State 3-19-2008| Lansdown, MD Donation 5 Other Specify: ĕ 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee North Avenue Balto, 21202 1101 E. Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Undanying Course (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 1 per me g878 4-15-08 vt UNPENDED attending physician or use as the burial -23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) nse 5 ned by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? has ✓ Yes 2 No 2 No 1 🗸 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Other<sub>4</sub> Be Residence 6 V Other: Scene Hospital: Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject shot Certification: FOUND: Yes 2 V No Natural 5 Pending Director: death. Mar 12, 2008 2257 hrs 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 2800 Block Denham Circle N, Baltimore, MD Could not be 24 hours after 3 Suicide (Specify) Local Street To the Hospital o within 24 hours af To the Funeral D determined 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 13, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

State Registrar

**ORIGINAL** 

31. Date filed (Ad it / Day, Y) + 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 07:22 PM Sidney Burnett, In April 06 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union memorial Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 XM 2□F 83 NC 216.16.0905 1204 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Baltmore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number W. Strathmore Avenue USA 21215 3210 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentist 5+ years 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Baldwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 3210 W. Strathmore Avenue Balto. MD 21215 ٧. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 04/12/08 Baltimore, MD Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee Road Rundallstown MD 21133 8728 Liberty Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** Due to (or as a consequence f): /Medical Examiner one year Severe Ling Disease Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a const uence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò pe 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? res 2 No 2 No 1∐ Yes 1 ☐ Yes Physiclan; 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Hospital or Attending 1 X Natural 2 ☐ Accident 5 Pending investigation thours after death.

-uneral Director; Afely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To th. within 24 o the Fir 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Santtino A. martin M.D. AT2438946 April 06, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Union memorial Hospital, MD Santhia A. Mathew M.D. 32. Registrar's signature 31. Date filed (Month, Day, Year) APR 1 0 2008 State O BULL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Month 230 M Physician RED /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL LINTHICUM TATE HOSPICE HOUSE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours DC1 M 2□F 1937 JAN 16, Director 577-50**-**0925 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County show 1 X Yes 2 No 28a-f sh notified Director PRINCE GEORGE'S SUITLAND MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or USA 20746 4709 WOODCREST COURT ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) h and Mental Hygiene.
7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Federal Government US Marshall Yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental I Mattie Edith Smith Alfred Robert Bell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important; If item 27 is any Injury or other trau. Suitland, MD 20746 4709 Woodcrest Court Azalene Bell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 DCremation 3 ☐ Removal from State METROPOLITAN CREMATORY 4-11-2008 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD rvice L ensee 20746 SUITLAND, MD Donald R. Gray 4308 SUITLAND ROAD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Parth. Enter the disease shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical ası IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No ţō 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: certificate has autopsy performed' 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS Pic Hospital: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient ٩ this HOUG 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? Certification: 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Division or Vital Records, To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

29a. Certifier

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and m ener stated.

29d Date signed (Month, Day, Year) 29c. License number

eted cause of death (Item 23a) (Type, Print) ame and address of perso 11CH MER 441 E

NN APOLISM DUIYO

State Registrar

Medical

31. Date filed (Many) 2008 Baltimore, Maryland 21215-0036 Department of H Important: If ite any Injury or ot **Physician** /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed after death. Division or Vital Records, P.O. Box 68760, To the Hospital

physician at the burial attending pl signed by the a page 2 s director this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite

other traumatic

Examine Certification: To Medical

Physician/Medical þ Be Completed

₹F FEMALE: 23b. Was decedent pregnant

4 Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and itle of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Day, Year) 31. Date filed (Month 10

Codar (gre Columbia MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 126 **Physician** CHARLES REGINALD BENNETT, III 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b\_City, Town, or Location of Death Examiner Year If Under 24 Hrs.
Hours Min. Social Spourity Number 6. Sex 1 M 2 ☐ F Date of Birth (Month, Day, Year) 11/12/1941 Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign) Months MARYLAND Director 216-36-4214 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 ☐ No Director MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1309 W. MADISON AVENUE, APT. B 21217 items 23a IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No **BLACK** Baltimore, Maryland 21215-0036 "natural", or Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MARYLAND MASS Department of Health and Mental Hygiene. important: if Item 27 is marked other than any Injury or other traumatin according Elementary/Secondary (0-12) 12TH College (1-4or 5+) MTA BUS DRIVER TRANSIT ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES R. BENNETT, JR. DORIS L. BUTLER ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES QUICKLEY / SON 3940 FRISBY STREET, BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 4/08/2008 WINDSOR MILL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Cause (Final ymphoma **Physician** diseas r condition resulting in death) Due to (or sea consequence of):

Prostatic CANCER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a 1 Yes 2 No P.O. 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy page performed certificate 2 No Division or Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 □ No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Man r of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury (Month, Day Year) 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Lakshmanan

10

2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:09 PM Richard Rennett 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Edgemere 2603 Lodge Forest Drive If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday **Funeral** 1 M 2 □ F Yrs Director 217-54-0729 3/3/1952 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worldon Examination and be notified at 1 ☐ Yes XX No Director Maryland Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 2603 Lodge Forest Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2XXXNo Specify: White \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver Manufacturing 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil if Health and Mental H item 27 is marked otl Daniel R. Bennett Bessie Levi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2603 Lodge Forest Dr. Edgemere, MD 21219 Mrs. Catherine Bennett Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages Department of Important: If it any injury or or o 2 ☐ Cremation 3 ☐ Removal from State Sagred Ht. of Jesus Cem 4/10/2008 Dundalk, Maryland 5 Dygler (Specify) 21. Signature of Funeral 22. Name and Address of Facility Service LA Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Pundalk, Maryland 21222
anter the mode of dying, such as cardiac or respiratory arrest. Part 1. Enter the disease, or complications that caused the de sh. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-transit / Ver that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. I Division of Vital Records, e Hospital or A 24 hours after e Funeral Direc

To the within 2

State

'Registrar

Medical

PHILIPNILATPUNI 31. Date filed (Month, Day, Year) APR 1 0 2008

29b. Signature and title of certifier

29a. Certifier

N GHY PHIL Registrar's Signature

PHYSTUIAN

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEUPITAROAD

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100284

29d. Date signed (Month. Day, Year)

2008

APRIL

BAC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 2008 6:30P M BARON THELMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/23/1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 X F MD 91 218-10-6845 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination and the modified at N/A M∏Yes 2 ☐ No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 6316 GREENSPRING AVENUE, #406 21209 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify: à 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND COMPUTER OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( JULIUS LEVY BESSIE SILBERMAN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a COCKEYSVILLE, permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. JOYCE MEDINA / DAUGHTER 516 PENNY LANE, 3altimore, 20b. Place of Disposition (Name of cemeters, cremators or other place)
BETH ISAAC
ADATH ISRAEL 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/09/2008 BALTIMORE, MD 22. Name and Address of Facility of Fune al Service SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications the cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the artificial causes the shock of the cause of the c Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐Yes 2X No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \mathbb{X} \) Other (Specify) \( \mathbb{HOSPICE} \) Hospital: 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A
detely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

completely

within 2

29a, Certifier

(Check only one)

DR. EDDIE NAKHUDA

31. Date filed (Month, Day, Year)

29b. Signature a

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

. Registrar's Signature

Model

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month Year Physician barbin, 4:40 AM Onorio 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Buy iew Care Center MI Baltimore Country Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 4, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ★M 2 □ F PA 218-18-4279 88 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Madical Examinary ust be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or UNITED STATES 434 JOPLIN STREET 21224 12. Was Decedent Ever in U.S. Acred Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours atter Department of Health and Mental Hygiene. Importent: If tiem 271s marked other than "naturel", or thei any injury or other treumatic event. The Marilles Externation 1 Never Married 2 Married WHITE imore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8TH ASSEMBLY GENERAL MOTORS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DANTE BARBINI EMELIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 434 JOPLIN ST., BALTIMORE, MARYLAND ANNETTE R. BARBINI/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/07/08 BALTIMORE, MARYLAND OAK LAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or omplimons that cause shock, or heart failure list on one cause on each Immediate Cause (Findisease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 SUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No this certificate has 1 Yes of or Attending Physicien: after death. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 KNo 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely tilled in by the tu 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 🗺 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier pril 4 2008 D35763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Grace A. Cord 13 Circle

Registrar DHMH 17 Rev 1/2001

State

32 Registrar's Signatur

Baltimore, md 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:06 AMM 2008 April James J. Cassels /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Wisconsin 1916 Feb 11, 327-01-9914 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. In: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√☐ No Director Greenbelt Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20770 22 Ridge Road #324 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: white Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry uni 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Christine Boma Bert James Cassels 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10435 EB White Ct Laurel, MD Fred Cassels/son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D nknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate has 2 1⊟ Yes Physiclan; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes Appatient Certification: To After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Duath Injury 5 ☐ Pending investigation (Month, Day Year tural 1 ☐ Yes 2 ☐ No 2/ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Pedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Monfh, Day, Year) 29b. Signature and title of certified

State Registrar Day

2008

31. Date filed (Month, Da

|                            |   |                | For State Registrar  | State                         | of Mar                                      |                                     | partment of H<br>ertificate of I                  |  |   | giene<br>Reg. No:          | 008                          | 11645   |
|----------------------------|---|----------------|--|-------------------------------|---|-------------------------------------|---|--|---|----------------------------|------------------------------|---|
|                            | D   |                | 1. Decedent's Name (First, Midd                                    | le, Last)                     |   |                                     |   |  | 2. Date of Dea<br>Month                       | ath<br>Day                 | Year                         | 3. Time of Death                                |
|                            | Physicia<br>/Medic  |                | Lewis  | Cru                           | tchf  | ield                                |   |  | APRIL   | - 7                        | 2008                         | 10:30 PM  |
|                            | Examin  |                | 4a. Facility Name (If not institutio                               | -                             |   |                                     | 4b. City, Town, or                                |  | h   | 4c. Co                     | ounty of Deat                |   |
|                            |   |                | 2901 E. Str<br>5. Social Security Number                           | 6. Sex                        |   | In yrs. last birthday               |   | imore                                    | 8. Date of Birth                              | h                          | N/                           | A<br>hplace (State or Foreign                   |
|                            | Funeral Director  |                | 213-14-4015  | 18 M 2□F                      |   | 84 Yrs.                             | Months Days                                       | Hours Min.                               | (Month, Day                                   | y, Year)<br>23 2           | Co                           | untry) MD                                       |
|                            | D   |                | Usual Residence of Decedent  |                               |   |                                     |   |  |   | 20 2                       |                              |   |
|                            | arylar<br>show  | _              | 10a. State 10b. County   |                               | 1   | Oc. City, Town or I                 |   |  |   |                            |                              | 10d. Inside City Limits<br>1 XYes 2 No          |
|                            | 28e-1   | Director       | 10e. Street and Number   | I/A                           |   | Balt                                | imore   | _  |   | 10= Citi                   | n of What Co                 |   |
|                            | with ta or  | Dir            | 281 S. Dall  | as Ct                         |   |                                     | 10f. Zip Code 2123                                | 1  |   | rog. Citize                | USA                          | untry?  |
|                            | death   | Funeral        | 11. Marital Status   | 12. Was De                    | ecedent Ev                                  | er in U.S. 13                       | . Was Decedent of H                               | ispanic Origin? (S                       | Specify Yes or No-                            | 14.                        | Race - Ame                   |   |
| 36                         | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-1 show other treumetic event, the Medical Examinatings be notified at | by Fur         | 1 Never Married 2 Mar<br>3 Widowed 4 Divorce                       | ried 1 XYes                   | Forces?<br>s 2 ☐ No<br>Give<br>r Dates:     |                                     | If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No            | n, Mexican, Puer<br>Specify:             | to Rican, etc.)                               | S                          | Black, White<br>pecify:      |   |
| Ş                          | 2 hou   | ted            | 15. Deceder  | nt's Education                |   | 16a. Dec                            | edent's Usual Occup                               | ation                                    |   | 16b. Kind                  | of Business/                 | lack<br>Industry                                |
| 21215-0036                 | filed within 72<br>Hygiene.<br>Ither then "nel  | Completed      | Elementary/Secondary (0-12)  | est grade complete<br>College | d)<br>(1-4or 5+)                            | life.                               | e kind of work done of<br>DO NOT use retired      | during most of wo<br>()                  | rking   |                            |                              |   |
|                            | filed w<br>Hygier<br>other th   |                | 12th 17. Father's Name (First, Middle,                             | / act)                        |   | Fo                                  | reman   | 18 Mother's Na                           | me (First, Middle,                            |                            | teelw                        | orker   |
| Maryland                   | d be f  | To Be          | Richard  | *                             | utch  | field                               |   | Lott                                     |   | WAIGON SE                  |                              | ohnson  |
| E<br>Z                     | 2 should be and Mental I is marked o  | Ĕ              | 19a. Informant's Name/Relations                                    |                               |   |                                     | ling Address (Street a                            |  |   | r, City or T               |                              |   |
|                            | Health a tem 27 is  |                | Rebecca Kno  | x-siste                       | r   | 308                                 | S. Maso   | n Ct. I                                  | Baltimo                                       | re, i                      | MD 2                         | 1231  |
| altimore,                  | of He<br>of He<br>if Item   |                | 20a. Method of Disposition 1   Burial 2 □ Cremation                | 3 □Removal fro                | m State                                     | 20b. Place of Disp<br>cemetery, cri | position (Name of<br>ematory or other place       | θ)                                       | Date  | 20c. Loca                  | tion - City or               | Town, State                                     |
| Ē                          | . Pages<br>tment of I<br>tent: If Its<br>jury or o  |                | *4 □Donation 5 □ Other (5  | Specify)                      | Olalo                                       |                                     | ion Cem.  |  | 11/08   | Bal                        | timor                        | e MD  |
| Ba                         | permit. Pages<br>Department of<br>Importent: If It<br>any injury or o<br>once.  |                | 21. Signature of Funeral Service                                   | Licensee                      |   |                                     | 22. Name and Addres                               | ľ  | MARCH FU                                      |                            |                              |   |
|                            |   |                | 23a. Part1. Enter the disease, o                                   | r complications tha           | it caused th                                | e death. Do not e                   |   |  |   |                            | imore                        | , MD 21202<br>Approximate                       |
|                            | Physician   |                | shock, or heart failure. List<br>Immediate Cause (Final            | -                             | _   | entia                               |   |  |   |                            |                              | Onset and Death                                 |
|                            | /Medical  |                | disease or condition resulting in death)                           | a                             |   | consequence of):                    |   |  |   |                            |                              | 2 1/23  |
|                            | Examiner  |                | Sequentially list conditions,                                      | b                             |   |                                     |   |  |   |                            |                              | ····  |
| 1                          | ed isit   | Examiner       | if any, leading to immediate cause. Enter Underlying               | Due t                         | to (or as a                                 | consequence of):                    |   |  |   |                            |                              |   |
|                            | icate be executed<br>physician and<br>s the burial-transit  | xan            | that initiated events resulting in death) Last                     | c                             | o (or as a                                  | consequence of):                    |   |  |   |                            |                              |   |
| 8760,                      | se be (   | dicai          |  | d                             |   |                                     |   |  |   |                            |                              |   |
| 9                          |   | <b>a</b>       | IF FEMALE.   |                               |   |                                     |   |  |   |                            |                              | (   |
| Box                        | death certifi<br>e attending<br>id for use as   | ian/           | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months? |                               | e birth 2                                   | Fetal death 3                       | Ectopic pregnancy                                 |  |   | 230                        | d. Date of deli<br>Month     | very<br>Day Year                                |
| P.O.                       | 0 00  | Physician/M    | 1 ☐ Yes 2 No<br>9 ☐ Unknown  | 4∐Pre<br>9□Uni                |   | ne of death 5                       | Other (specify)                                   |  |   |                            |                              | ,   |
|                            | The law requires that the tee has been signed by thoage 2 should be detached.   | by Ph          | Part II. Other significant conditi                                 |                               |   | not resulting in the                | underlying cause give                             | en in Part I.                            | 23e. Did to                                   | bacco use                  | contribute to                | the cause of death?                             |
| rds                        | equire:   |                | colon  | cancer                        |   | periph                              | . vasc.   | disease                                  | 1□Y   | ′es 2 🗆 !                  | No 3□Pro                     | obably 4 Unknown                                |
| Division of Vital Records, | law requ<br>as been<br>2 should   | Completed      | ートナン   |                               |   |                                     |   |  | 24a. Was a                                    | an 2                       | 24b. Were au                 | topsy findings available completion of cause of |
| <u> </u>                   |   | Con            |  |                               |   |                                     |   |  | perfor  | med?<br>2 No               | death?<br>1 ☐ Yes            |   |
| VII                        | Physicien: Th<br>r this certificate<br>ral director, pag  | Be             | 25. Was case referred to medica examiner?                          | Hospital:                     |   |                                     | ent 3CDOA Othe                                    |  | ath (Check only or                            |                            |                              | ESTLEY  |
| ō                          | hys<br>l dii  | . To           | 1 Yes 2/2 No 27. Manner of Death                                   | 28a. Dat                      | Inpatient<br>te of Injury                   | 28b. Time                           | SIL SU DOA  | 4 Linuising i                            | dome 5 Resid                                  |                            | her (Spec                    | Asst.   |
| 0                          | nding I<br>tth.<br>r: After<br>e funer  | atior          | 1 Natural 5 ☐ Pendii<br>2 ☐ Accident invest                        |                               | onth, Day Y                                 | (ear) Injury                        | of 28c. Injury<br>Work<br>M 1 []                  | k?<br>Yes 2□No                           |   |                            |                              | Live La   |
| N N                        | r Atter   | Certification; | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                       | nined 289. Pla                | ice of Injury                               |                                     | treet, factory, office                            |  | 28f. Location (S<br>City or Tow               |                            | Vumber or Ru                 | ral Route Number,                               |
| 5                          | itei or<br>urs aft<br>ral Di<br>lled in   |                |  | 1                             |   |                                     |   |  |   |                            |                              |   |
|                            | To the Hospitei or Attending Pi<br>within 24 hours after death.<br>To the Funeral Director: Atter to<br>completely filled in by the funeral   | Medical        | 29a. Certifier 1. ☐ Certifyii (Check only one) 2 ☐ Medical         | Examiner: On the              | the best of a<br>basis of ea<br>anner state | kamination and/or i                 | th occurred at the tim<br>investigation, in my op | ne, date and place<br>pinion, death occi | e, and due to the our<br>urred at the time, o | cause(s) ar<br>date and pl | nd manner as<br>ace, and due | stated.<br>to the cause(s)                      |
|                            | o the   | Me             | 29b. Signature and title of certifie                               |                               |   | u.                                  | 29c. License                                      | number                                   | 2   | 29d. Date s                | signed (Month                | n, Day, Year)                                   |
|                            | 0 1   |                | > marshen  | ( nu                          | ale   | 8                                   | DY  | 4575-                                    | 7   | APA                        | ech 8                        | , 2008  |
|                            | 11.11   |                | 30. Name and address of person                                     | who completed ca              | use of dea                                  | th (Item 23a) (Type                 | Print)  |  |   |                            |                              | 7 7711  |
|                            | Jeg 1   |                | Matthew  31. Date filed (Month, Day, Year,                         | MCNF                          | - S N (                                     | 4 4 9                               | 40 80   | stern                                    | Balt  | ans                        | re L                         | 10 21224  |

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:05A APRIL Abram Coles Sr. Charles 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homelton Center 6040 HAR PORD NIA BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5 (Month Pay, Year) 926 5. Social Security Number Birthplace (State or Foreign Country) Hours Months Days 227-20-9624 81 VA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 6219 Fair Oaks Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Laborer Lucent Technology 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruby Cason William Coles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6219 Fair Oaks Ave. Baltimore, MD 21214 Gloria Coles-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Loudon Park Cem. 4-10-08 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, MD 21202 I and wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MARCHTIA STAGG GUD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY DISCATE

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mentai Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or awy Injury or other traumatic event, the Medical Examiner must be r. once.

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

death with the Maryland

attending physician and for use as the burial-tran signed by the a page 2 s certificate rthis c

the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown CARDIOMYOPATH

1 Yes 2 No 3 Probably 4 Unknown

24a, Was an autopsy performed? 2 No 1☐ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

8 2008.

25. Was case referred to medical examiner?

1 Yes 2 40 27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifler

4 Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

TROWDING

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HARPORD RD.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific

29c. License number PHYSICIAN 20062239

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DK MAW NAING OO, MD Hamilton Center 31. Date filed (Month, Day, Year)
APR 1 0

6040 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ... Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** 7:05am 4 2 Margaret Louise Chase 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X N.C. Director 216-09-5841 8-6-1915 89 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code J S A 14. Race - American Indian, Black, White, etc. 21218 1504 Northqate Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ⊋☐ No Specify þ Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Finance Officer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) l and 2 should be fil lealth and Mental H Be ပ Benjamin Taylor <u>Geneva Cotton</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Janice Page - Daughter 1504 Northgate Road Balto, MD 21218 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 4-7-2008 Arbutus, MD 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee Glady Won Ε. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on y ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner physician and s the burial-transit Due to (or as a consequence of Box 68760, pe Physician/Medical as IF FEMALE: use If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 pronths? Month Year 5 Other (specify) P.O. 1 ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2∏ No 1 □Yes 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🔲 Inpatient ER/Outpatient 2 3□ DOA After this 27. Manner of Death
1 Natural
2 □ Accident To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 4 - 4 - 200 8 29b. Signature and the of certifier

0 State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

601



**ORIGINAL** 

Blud, Baltimore no 21239

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITING per HVS. C878, 4/10/08 VS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

|                     |  | -                   | For<br>State<br>Registrar   | Otate of Mai   |  | ertificate of I   |   | Reg   | . No. 2000                                   | 0. 11610                             |
|---------------------|--|---------------------|---|--|--|---|---|---|--|--------------------------------------|
| F                   | Physicia   | an                  | 1. Decedent's Name (First, Middle, Last   |  |  | ·   |   | <ol><li>Date of Death<br/>Month,</li></ol>    | <b>29</b>                                    | 3. Time of Death                     |
|                     | /Medic   | al                  | 4a. Facility Name (If not institution, give   |  |  | 4h City Town or   | Location of Death                           | march -                                       | 4c. County of Deat                           | 7:00a. <sup>™</sup>                  |
|                     | Examin   | er                  | 1802 Wycliff  |  |  | Dark  |   |   | Bach.  | noc                                  |
|                     | Funeral<br>Director  |                     | 5. Social Security Number 6. Se   |  | 73 Yrs.                                  | y) If Under 1 Year<br>Months Days                                     | If Under 24 Hrs. Hours Min.                 | 8. Date of Birth (Month, Day, Y               | ear) Co                                      | hplace (State or Foreign untry) N.C. |
|                     | pus w  |                     | Usual Residence of Decedent  10a. State 10b. County                                   | 1  | 0c. City, Town or                        | Location  |   |   |  | 10d. Inside City Limits              |
|                     | Maryla<br>f sho<br>ied at  | to                  |   | lto  | Parkvi                                   | 11 <del>e</del>   |   |   |  | 1 □ Yes 2 □ No                       |
|                     | th the   | irec                | 10e. Street and Number  | _  |  | 10f. Zip Code   | 004   | 10g   | . Citizen of What Co                         | untry?                               |
|                     | ath wii<br>23a<br>ust b  | ral                 | 1802 Wycliffe R   |  |  |   | 234   | ocifu Ves or No-                              | U S A  | rican Indian.                        |
| 036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced           | 12. Was Decedent Ev<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give X<br>Year or Dates: | er in U.S.                               | 3. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☐ No         | Specify:                                    | Rican, etc.)                                  | Black, Whit                                  | ack                                  |
| 2-<br>0-            | 72 ho<br>'natur<br>dical I   | eted                | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. De                                  | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retire | oation<br>during most of worki              | ng 16   | 6b. Kind of Business/                        | Industry N/A                         |
| 121                 | within<br>ene.<br>than "   | Completed           | Elementary/Secondary (0-12)   | College (1-4or 5+)   | ·  | Disabled  | <u> </u>                                    |   |  |                                      |
| Maryland 21215-0036 | Hiled I Hygid  | Be Co               | 12th grade<br>17. Father's Name ( <i>First, Middle, Last</i> )                        | N,   | / A                                      | DIBUDICA  | 18. Mother's Name                           | (First, Middle, Ma                            | aiden Surname)                               |                                      |
| ylan                | ould be<br>Menta<br>arked<br>atic ev   | To B                | Matthew Morris  | _  | 1/2                                      |   | Maebell                                     |   |  | 7:- 0- 4-1                           |
| Mar                 | 12 sho<br>h and<br>7 is ma<br>trauma   |                     | 19a. Informant's Name/Relationship (Tarlie Cox-Hus                                    |  |  | ailing Address <i>(Street</i><br>02 Wycli                             |   |   |  |                                      |
|                     | s 1 and 2 and 1 and 2 and 1 an |                     | 20a. Method of Disposition  |  |  | sposition (Name of crematory or other pla                             |   |   | Oc. Location - City or                       |                                      |
| ē                   | Pages<br>nent of<br>nt: If ii  |                     | Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                              |  |  | ville Ve  |   | 2008  | Crownsvi                                     | lle, MD                              |
| Baltimore,          | permit. Departir Importa any inju  |                     | 21. Signature of Funeral Service Licer  | isee   |  | 22. Name and Addre  |   | larchEas                                      | •  | WD 21202                             |
|                     | 9 2 E B 9  |                     | 23a. Part1. Enter the disease, or com   | 2 Was  | he death Do not                          |   |   |   | Balto, I                                     | Approximate                          |
| e                   |  |                     | shock, or heart failure. List only  | one cause on each line   | ne death. Bo not                         | enter the mode or dy  | ng, outline saidae                          | or roopmator, aires                           | ,  | Interval Between<br>Onset and Death  |
|                     | Physician /Medical   |                     | disease or condition resulting in death)  | a. Ascon<br>Due to (or as a  | consequence of):                         |   |   |   |  | years                                |
|                     | Examiner   |                     | Sequentially list conditions  | b  |  |   |   |   |  |                                      |
|                     | <b>7</b> 8 ts  | iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying    | Due to (or as a  | consequence of):                         |   |   |   |  |                                      |
| 1                   | tificate be executed<br>g physician and<br>as the burial-transit   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last               | c. Due to (or as a   | consequence of):                         |   |   |   |  |                                      |
| 68760,              | te be e<br>ysiciar<br>ie buri  | edical              |   | _d   |  |   |   |   |  |                                      |
|                     | ertifica<br>ing ph   | Medi                | IF FEMALE:  |  |  |   | 7   |   | 001 D 4 4 4                                  |                                      |
| .O. Box             | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/M         | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown | 23c. If yes, outcome p<br>1 ☐ Live birth 2<br>4 ☐ Pregnant at 1<br>9 ☐ Unknown             | ☐ Fetal death                            | 3 □Ectopic pregnand<br>5 □ Other (specify) _                          | cy  |   | 23d. Date of de<br>Month                     | Day Year                             |
| Δ.                  | ires that the de<br>signed by the a<br>I be detached I   | by Ph               | Part II. Other significant conditions   | contributing to death bu   | t not resulting in th                    | e underlying cause gi   | ven in Part I.                              | 23e. Did toba                                 |  | to the cause of death?               |
| rds                 | w requires<br>been sign<br>should be   | ed b                | CUA with hemip  | elyin and  | dysphisi                                 |   |   | 1 ☐ Ye  | s 2 <b>,⊒+1</b> 6 3∏F                        | Probably 4 □Unknown                  |
| or Vital Records,   |  | Completed           | Services  |  |  |   |   | 24a. Was an<br>autopsy<br>perform<br>1□ Yes 2 | prior to                                     |                                      |
| Vita                | sician: The<br>certificate<br>rector, pag  | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |  | 07 004 01   | har:  | th (Check onl one                             |  | anif d                               |
| o                   | Phys<br>ar this<br>eral dir  | To                  | 1 ☐ Yes 2 ☐ ¶o  27. Manner of Death   | 28a. Date of Injur   |  | ne of 28c. Inju   | 4 🗆 Nulsing H                               | 28d. Describe ho                              | nce 6 □Other (Sp<br>w injury occurred        | өспу)                                |
| ion                 | ath.<br>rr: Afte   | atior               | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio                                     |  | Year) Inju                               |   | Yes 2 No                                    |   |  |                                      |
| Division            | or Atte<br>fter dea<br>Directo   | Certification:      | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                                |  | ry - At home, farm<br>. <i>(Specify)</i> | , street, factory, office   |   | 28f. Location (Str<br>City or Town            | eet and Number or F<br>, State)              | Rural Route Number,                  |
|                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, to   | Medical Ce          | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa                          | hysician: To the best of<br>miner: On the basis of<br>and manner sta                       | examination and/                         | death occurred at the<br>or investigation, in my                      | time, date and place<br>opinion, death occu | , and due to the ca<br>rred at the time, da   | ause(s) and manner a<br>ate and place, and d | as stated.<br>ue to the cause(s)     |
|                     | To the within To the compli  | Me                  | 29b. Signature and title of certifier   |  |  | 29c. Licer  | nse number                                  | 29  | d. Date signed (Mo                           | nth, Day, Year)                      |
|                     |  |                     | b wind x  | les mo   |  |   | 51295                                       |   | 3/31/08                                      |                                      |
|                     | 5  |                     | 30. Name and address of person who  | completed cause of de  | eath (Item 23a) (Ty                      | (pe, Print)   | 4202 7                                      | Towsen:                                       | md 212                                       | مره ه                                |
|                     | S  | ate                 | 31. Date filed (Month, Day, Year)   | 32 Registra  | ar's Signature                           | St Suite  |   |   |  |                                      |
|                     | Regis  |                     | APR 1 0 20  | 08 Steam   | 1 St 16                                  | parke   |   |   |  |                                      |

| Christine Clark   |   | State of Maryland / Department of Health and Mental Facilities Certificate of Death   |   | 20 L                          | 18 1164   |  |  |  |  |  |  |
|---|---|---|---|-------------------------------|---|--|--|--|--|--|--|
| Physiciar<br>Vledical Examin  | Registrar    Softmatt of Death   Reg. No.   |   |   |                               |   |  |  |  |  |  |  |
| Joseph Brainn   |   | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea  |   | 4c. County of Death           |   |  |  |  |  |  |  |
| Funeral   | 4   | Good Samaritan Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H   | Irs. 8. Date of Birth                                   | n(MM/DD/YYYY) 9. Bir          |   |  |  |  |  |  |  |
| Director  |   |   | in. 12-25   | -1950 Foreign                 | ountry) D   |  |  |  |  |  |  |
| any   | -   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |   |                               | 10d. Inside City Limits                           |  |  |  |  |  |  |
| *   | _   | MD N/A Baltimore  |   |                               | Yes 2 No  |  |  |  |  |  |  |
| Maryla  | Director  | 10e. Street and Number 10f. Zip Code 4403 Chalet Ct Apt 1 C 21206   | 10  | g. Citizen of What Cou<br>USA | ntry?   |  |  |  |  |  |  |
| with the Maryland ns 23a or 28a-f sho be notified at once.  | 直   | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (   |   |                               | ican Indian, Black,                               |  |  |  |  |  |  |
| r death   | Fune  | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No  | rto Rican, etc.)  | White, etc.                   | Black   |  |  |  |  |  |  |
| ours afte   | d b   | 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of August 1997) 16a. Decedent 1997) 16a. Decedent 1997) 16a. Decedent 1997) |   | 16b. Kind of Business         | Industry Unk                                      |  |  |  |  |  |  |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once | Completed by Funeral  | Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade N/A Disabled  | elired)   |                               | Ollk  |  |  |  |  |  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | 통<br>당  | 17. Father's Name (First, Middle, Last)  18. Mother's Name  | me (First, Middle, M                                    | •                             |   |  |  |  |  |  |  |
| 2121<br>ald be fi<br>Mental<br>marked   | To Be   | George Johnson Melvir  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of  | ber, City or Town, State                                | e, Zip Code)                  |   |  |  |  |  |  |  |
| MD d 2 shot lith and n 27 is aumatic  |   | Pauline Peoples-Niece 307 Millington Av   | 1223  |                               |   |  |  |  |  |  |  |
| Baltimore, MD 21215<br>permit. Pages I and 2 should be file<br>Department of Health and Mental II.<br>Important: If tiem 27 is marked of<br>injury or other traumatic event, ti   |   | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  | Date  | 20c. Location - City o        |   |  |  |  |  |  |  |
| Baltimore,<br>permit. Pages 1 a<br>Department of He<br>Important: If ite  | ŀ   | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  | -5-2008<br>March F                                      | Balto,                        | D 21202   |  |  |  |  |  |  |
|   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac   |   |                               | Approximate Interval                              |  |  |  |  |  |  |
| Physician<br>'Medical   |   | failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of chronic alcoholism   |   |                               | Between Onset and<br>Death                        |  |  |  |  |  |  |
| kaminer   |   | or condition resulting in death)  Due to (or as a consequence of):  |   |                               |   |  |  |  |  |  |  |
|   | <u>la</u>   | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause   |   |                               |   |  |  |  |  |  |  |
| / p .is   | Examiner  | (Disease or injury that initiated events resulting in death) Last    C.   Due to (or as a consequence of):  |   | ·                             |   |  |  |  |  |  |  |
| execuian and  | ledical E   | X UNPENDED  |   |                               |   |  |  |  |  |  |  |
|   |   | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic prec  |   | 23d. Date of delive           | ·   |  |  |  |  |  |  |
| Box 68760, e death certificate be the attending physicied for use as the buri   | Physician/N   | past 12 months?  4 Pregnant at time of death  5 Other (Specify)   | gnancy  | Mortin                        | Day Year  |  |  |  |  |  |  |
| gc th   |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did to   | bacco use contribute to       | o the cause of death?                             |  |  |  |  |  |  |
| S, P.O. Lines that th   | Completed by  |   | -   | 2 ✓ No 3 Pro                  |   |  |  |  |  |  |  |
| cords,<br>law requir  | nplet   |   | 24a. Was autop  |                               | autopsy findings available completion of cause of |  |  |  |  |  |  |
| tal Recionant The certificate ector, page   |   | 25. Was case referred to medical 26.Place of Death (Che   | 1 ✓ Yes   | 2 No 1 🗸                      | res 2 No  |  |  |  |  |  |  |
| 'Vita   | 10 Be   | TV Tes 2 No   |   | Residence 6 Oth               | er:   |  |  |  |  |  |  |
| ion of tending Pheat.  Ior: After the funeral   | Ęį  | 27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  | 28C. Describe   | how injury occurred           |   |  |  |  |  |  |  |
| Division of Vital Records, 14 Hospital or Attending Physician: The law require 15 hours after death. Funcral Director: After this certificate has been si   | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) |   |   |                               |   |  |  |  |  |  |  |
| Divi  | ပ႑  | 4 Homicide determined (Specify)  29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a   | and due to the caus                                     | e(s) and manner as sta        | ated.   |  |  |  |  |  |  |
| To the Hos within 24 h To the Fu  | Medical   | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  | ed at the time, date                                    | and place, and due to         | the cause(s)                                      |  |  |  |  |  |  |
|   | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Y  March 29, 2008   |   |   |                               |   |  |  |  |  |  |  |
| inxpera   | -   | 30. Name and address of person who completed cause of death (Item 23a)  |   | I                             |   |  |  |  |  |  |  |
| Sta   | te.   | Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, I  31. Date filed (Month, Day, Year). 32. Figistrar's Signature  | MD 21201  |                               |   |  |  |  |  |  |  |
| Registr   |   | . #UDY T 1) 2000   Wa   | Date filed (Month, Day, Year) 32. Figistrar's Signature |                               |   |  |  |  |  |  |  |

DHMH 17 Rev 1/2001

OCME

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8<sup>Pay</sup> 2008 ear April 1 7:00A ALEXANDER LACY CUMMINGS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1915 Oak Lodge Road Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) 2. Maryland **Funeral** Min. February 14,1942 1**XX**M 2□F 219-42-0349 66 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Directo Towson Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 21204 7333 Yorktowne Drive USA 23a death v Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1000 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married Married 1 ☐ Yes 2 1 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer State of Maryland permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cummings Marie Collins Lacy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hubbard Cummings Wife 7333 Yorktowne Drive Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 □Cremation 3 □Removal from State □Donation 5 □ Qther (Specify) New Cathedral Cemetery 04/11/2008 Baltimore, Maryland rvice Licensee 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, MAryland 21212 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part1. Enter the disease, or com shock, or heart fairure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE CHNCEN **Physician** MEHASTATIC 8 YEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dury to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) physician are the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical as IE FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Sister's 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence XXOther (Specify) Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 □ Yes 2 □ No within 24 hours after death To the Funeral Director:.. completely filled in by the 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

APR 10 DHMH 17 Rev 1/2001

29h Signatur

e and title of certifier

31. Date filed (Month, Day, Year)

A. EIRENBERGER

30. Name and address person who compared cause of death (Item 23a) (Type, Print)

2008

MD JOHNS

32. Registrar's Signature

29c. License number

DS8368

HOPKINS MSPIAL 1650 DRIFFANS CO

29d. Date signed (Month, Day, Year) 4/09/2000

Ö Vital within 2

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of

3721

31. Date filed (Month, Day, Year)

30 Hame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

POTEL

PACTIMONE.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 1 8, 2008 4:30 P. M Physician Alvera V. Casev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville Oak Crest Care Center 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
October 10, 1913 Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 94 Yrs. 213-30-0931 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 9905 Whitworth Way Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Claims Adjuster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Wiedeck Alva W. Vovce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9905 Whitworth Way Ellicott City, Maryland 21042 Pages 1 and 2 of Health a John J. Casey/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Garden\$ 4/11/08 Timonium Maryland Leonard J. Ruck, Thc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee pustine llon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) vascular **Physician** Cerebral /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩o 24a. Was an autopsy performed? 1□ Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)58646 a monies MD

State Registrar

Anna

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Walther Boulevard Bockville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

32. Restrar's Signature

Monias

APR 1 0 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (10.00)

|                     |   |                     | 1- State - State - Ana Bd G8784/06  |   | Reg.                                       | 4000  | 11653                                     |
|---------------------|---|---------------------|---|---|--|---|---|
| À                   | Physici   | an                  | 1. Decedent's Name (First, Middle, Last)  |   | Date of Death     Month                    | Day Year  | 3. Time of Death                          |
| 1                   | /Medic  |                     | Vincent Davis   |   | -  |   | 6:15 PM <sup>M</sup>                      |
|                     | Examin  | er                  | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  |  | 4c. County of Death                                       |   |
|                     |   | m                   | Springbrook Nursing Home  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   | Silver Spring  If Under 1 Year   If Under 24 Hrs.   | 8. Date of Birth                           | Montgomery  | (01-1                                     |
| Ġ                   | Funeral<br>Director   |                     | 5. Social Security Number  231-28-3953  Usual Residence of Decedent  6. Sex 1   M 2 □ F  7. Age (In yrs. last birthday, Yrs.  85  Yrs.  | Months Days Hours Min.  | (Month, Day, Yes                           | ari Countr  | nce (State or Foreign<br>y) unk           |
|                     | land<br>ow  |                     | 10a. State 10b. County 10c. City, Town or L   | ocation   |  | 100   | d. Inside City Limits                     |
|                     | Mary<br>Fied a  | ţō                  | DC Washi  | ngton   |  |   | 1 □Yes 2 No                               |
|                     | th the  | )irec               | 10e. Street and Number  | 10f. Zip Code   | 10g.                                       | Citizen of What Country                                   | y?  |
|                     | 23a ust b   | la l                | 1326 S Street SE  | 20020   |  | USA   |   |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>ed other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status unk  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  14. Marital Status Unk Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Give Year or Dates: | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify: |  | 14. Race - Americar<br>Black, White, et<br>Specify: blace | ck  |
| 5-0                 | 72 h<br>'natu<br>dical  | Completed by        | (Specify only highest grade completed) (Give  | edent's Usual Occupation<br>e kind of work done during most of work                               | un 16b                                     | . Kind of Business/Indu                                   | unistry unis                              |
| 121                 | within sne. than '  | Idm                 | Elementary/Secondary (0-12) College (1-4or 5+) unk  | DO NOT use retired)   |  |   |   |
| d 2                 | filed<br>Hygie<br>ther  |                     | 17. Father's Name (First, Middle, Last)   | unk 18. Mother's Nam  | e (First, Middle, Maid                     | den Surname)  | unk                                       |
| lan                 | 2 should be filed and Mental Hygic Is marked other raumatic event, the  | To Be               |   |   |  |   |   |
| аZ                  | shou<br>and M<br>s mar<br>umat  | -                   |   | ing Address (Street and Number or Rui   |  |   |   |
|                     | 라 돌 Z 후   |                     | Springbrook Nursing Home 1233   | 24 New Hampshire A  | venue Silv                                 | er Spring,  | MD 20901                                  |
| Baltimore,          | permit. Pages 1 ar<br>Department of Hea<br>Important: If item :<br>any Injury or other  |                     | 4 □ Donation 5 <del>Mother (Specify)</del> in state   | osition (Name of<br>ematory or other place)   | Date 20c                                   | . Location - City or Tow                                  | n, State                                  |
| Balt                | permit. Depart Import any inj   |                     |   | z Name and Address of Facility<br>Late Anatomy<br>altimore, MD 2120                               |  | altimore S  | Street                                    |
|                     |   |                     | 23a. Part. Enter the divides or complications that caused the death. Do not en show, or heart failure. List only one cause on each line.  | ter the mode of dying, such as cardiac  | or respiratory arrest,                     | 1   | Approximate<br>Interval Between           |
| B                   | Physician   |                     | Immediate cause (Final disease or condition a End stage lung  | cancer  |  |   | Onset and Death                           |
|                     | /Medical<br>Examiner  |                     | Due to (or as a consequence of):  |   |  |   |   |
|                     |   | <u>*</u>            | Sequentially list conditions, if any, leading to immediate cause filter throughing.   |   |  |   |   |
|                     | ted<br>nsit   | nin                 | Cause (Disease or injury that initiated events  |   |  |   |   |
| ,                   | rtificate be executed og physician and as the burial-transit  | Examiner            | resulting in death) Last c.  Due to (or as a consequence of):   |   |  |   |   |
| 68760,              | te be<br>ysicia<br>e bur  |                     | d   |   |  |   |   |
|                     | tifica<br>g ph<br>as th   | Medical             |   |   |  |   |   |
| P.O. Box            | The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use   | Physician/          |   | □Ectopic pregnancy □ Other (specify)  |  | 23d. Date of delivery<br>Month D                          | y<br>Day Year                             |
|                     | w requires that<br>been signed b<br>should be deta  | þ                   | Part II. Other significant conditions contributing to death but not resulting in the  | ınderlying cause given in Part I.   |  | co use contribute to the                                  |   |
| I Records,          |   | Completed           |   |   | 24a. Was an autopsy performed              | prior to comp<br>death?                                   | sy findings available pletion of cause of |
| Vital               | clan:<br>ertific  | Be (                | 25. Was case referred to medical examiner?  |   | th (Check only one)                        |   |   |
| or                  | Physician:<br>r this certific<br>ral director,  | 2                   | 1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatie  |   |  | e 6 □Other (Specify)                                      |   |
| OU C                | Ing<br>Affe<br>une  | ion:                | 27. Manner of Death 28a. Date of Injury 1 Sylatural 5 Pending (Month, Day Year) Injury  | Work?   | 28d. Describe how in                       | njury occurred  |   |
| Division            | ir Attentier death  | Certification:      | 2   |   | 28f. Location (Street<br>City or Town, St  | t and Number or Rural i<br>tate)                          | Route Number,                             |
|                     | To the Hospital of within 24 hours aft To the Funeral D completely filled in  | Medical Co          | 29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.  | th occurred at the time, date and place, nvestigation, in my opinion, death occu                  | and due to the causerred at the time, date | e(s) and manner as sta<br>and place, and due to t         | ited.<br>the cause(s)                     |
|                     | ro the<br>vithin<br>ro the  | Me                  | 29b. Signature and title of certifier   | 29c. License number   | 29d.                                       | Date signed (Month, Date                                  | ay, Year)                                 |
|                     | ->=0  |                     | I ( // for A) I have ( ) as   | D52261  | Ma   | rch 2, 2008   | 3   |
|                     |   |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type  |   |  |   |   |
|                     |   |                     |   | rcle Silver Sprin   | ng ,MD 209                                 | 06  |   |
|                     | Sta<br>Registr  |                     | 31. Date filed (Morth Page Year) 2008 Registrar's Signature   | uli   |  |   |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 8 **Physician** 9:40 am M 04 06 Carol Jean Duff /Medical 4b\_City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Valisbury Wiconico at the Lake Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕏 F 69 May 13, 1938 Rhode Island Director 035-24-8831 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 'natural', or items 23a or 28a-f shov dical Examiner must be notified <u>at</u> 1 ☐ Yes 2√☐ No Director MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 303 Andover Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Armed Folces:
1 Nes 2 No
If Yes, Give
Year or Dates: 162-78 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 military officer USAF permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important; if item 27 is marked other any injury or other traumatic event, if any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Linwood Duff Margaret Sinclair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Willaims/spouse 303 Andover Drive Salisbury, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Ronald 222 Baltimore, MĎ a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, a heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** montes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No ed by the 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 be 1 ☐ Yes 2 ☐ No 3 ₹ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2★ No page 2 s has autopsy certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 BOther (Specify) Hospice Hospital: 1 ☐ Yes 2 ☑ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: Division

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M. D. 5302 CHINABERRY DR., SALISBURY, MD The state of

29c. License number

29505

29d. Date signed (Month, Day, Year)

04 - 06 - 2008

State

29b. Signature and title of certifier

08-02658 Gary M Dike Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Gary Mark Dike 1348 hrs April 4, 2008 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Columbia Howard Howard County General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Idaho Months Days Min Apr 12, 1940 Director 1 M 2 F 67 511-40-8098 Usual Residence of Decedent 10d. Inside City Limits ij 10c. City, Town or Location 10a, State 10b. County **Ellicott City** Howard 1 Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? A. 10e. Street and Number 10f. Zip Code 21042 10315 Burnside Dr. 12. Was Decedent Ever in U.S.

13. Was Decedent of Hispanic Origin? (Specify resources)

14.3/1963 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral Race - American Indian. Black. Was Decedent of Hispanic Origin? ( Specify Yes or No-White, etc. White 1 Never Married 2 Married Yes No 1/30/1965 If Yes, Give Year 2 X No specify: Specify: Yes 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Social Security Elementary/Secondary (0-12) Computer Manager other than the Medical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo Dike If item 27 is marked her traumatic event, I 2121 Be Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 10315 Burnside Dr. Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) 9 Paula M. Dike 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place)
All County Cremation Services Apr 07, 200\$ Sykesville, Maryland Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: 22. Name and Stacks Purietal Home, P.A Eignature of Funeral Service Licensee 3871 Old Columbia Pike Ellicott City, MD 21043 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician veen Onset and failure. Listonly one cause on each line. Medical Death a. Occlusive Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep Venous Thromboses Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical **AMENDED** UNPENDED Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown ۵. Hypertensive Atherosclerotic Cardiovascular Disease, Diabetes Mellitus, Chronic Completed of Vital Records, 24b. Were autopsy findings available 24a. Was an Obstructivfe Pulmonary Disease autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 🗸 Yes ٤ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 🗸 Natural Division Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 5, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 12 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature State U Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMNO TIEW/8, perFH, C8/8, 4/16/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month Year **Physician** 7, 5:46 A M APRIL DINKINS ROBERTA VIRGINIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S 7204 PATTERSON STREET T.A NHAM Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Agamo, Dalo e a 1960 **Funeral** Min. Months Days Hours 1 □ M 2 💢 F DC Director 578-90-1224 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Director PRINCE GEORGE'S LANHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7204 PATTERSON STREET 20706 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ ear or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event ones. Be Evelyn Orr Robert Morell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lanham, MD 20706 7204 Patterson Street Eric W. Dinkins / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 04-09-2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee 20746 Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Port . Enter the disease, o shock, or heart failure. Li Immediate Cause (Final **Physician** Non-Small Cell Carcinoma of Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🔯 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 X No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician nse has certificate the Hospital or Attending Physician: this after death Director: filled in by

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show aţ

items 23a or 28a-f sh ner must be notified

'natural', or iter dical Examiner

the

other !

within 24 hours a To the Funeral L 7 State

Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ROBERT H. GERARD

obert H Huard

APR 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1500 Forest Glen Road

32. Registrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MD D0055522

Silver Spring, MD

29d. Date signed (Month, Day, Year)

APRIL 8, 2008

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
amend #19b Per FH G878 4/10/08 reflecte of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year **Physician** 13 attie Pril D006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HNS If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 50-6 1 M 2 M a. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medic M Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits undalk ttimore 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. Yes 2 ↑ f Yes, Give rear or Dates: 2010 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) urses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, State, Zip Code) Waymouth 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Buthmore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) INVIE /Medical Due to (or as a consequence of): ROMBOST **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 2∐No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 21 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury I Director: After t d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Tyes 2 | No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2000

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DHMH 17 Rev 1/2001

State

Registrar

strar's Signature

Carlo Sin

FSTERILL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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|                                     |  |                  | For State  | State of Mary   |                                |   |  | l Mental Hy                                | giene                     |                                     |  |
|-------------------------------------|--|------------------|--|---|--------------------------------|---|--|--|---------------------------|-------------------------------------|--|
|                                     |  | -                | 1 State Registrar  1. Decedent's Name (First, Middle, L                            | act)  | Cei                            | rtificate of I                                | Death                                  | 2. Date of De                              | Reg. No.                  | 2008                                | 3. Time of Death                       |
|                                     | Physici  |                  | - 1  | ' '   | unson                          |   |  | Month                                      | Day                       | Year 2008                           | 2:44 AM                                |
|                                     | /Medio   |                  | 4a. Facility Name (If not institution, g   |   |                                | 4b. City, Town, or                            | Location of De                         | ath April                                  | 4c.                       | County of Death                     | 1                                      |
|                                     |  | SSAN .           | 5: na: 1405 p: 1<br>5. Social Security Number 6.                                   | al of Beltim  |                                | Balt  | more                                   |  |                           | N/A                                 |  |
|                                     | Funeral<br>Director  |                  | 5. Social Security Number 6.   | Sex 7. Age (Ir<br>1 M 2 <b>X</b> F                                | yrs. last birthday)<br>63 Yrs. | If Under 1 Year<br>Months Days                | If Under 24 H<br>Hours Mi              |  | rth<br>ay, Yea <i>r)</i>  | 9. Birth                            | pplace (State or Foreign intry)        |
|                                     |  |                  | Usual Residence of Decedent  |   | Ψ,                             |   |  | 11 12                                      | 197                       | +                                   | 1-10                                   |
|                                     | arylano<br>show  | _                | 10a. State 10b. County   |   | c. City, Town or Lo            |   |  |  |                           |                                     | 10d. Inside City Limits 1 ☐ Yes 2 💢 No |
| <                                   | he Ma<br>28a-f s<br>otifie   | ecto             |  | tmore   | Owings                         |   |  |  | 10 m Citi                 | zen of What Cou                     |  |
| 20502                               | with t   | Funeral Director | 2016 Hunting   | Ridgo Drive   | 3)                             | 10f. Zip Code                                 | 1117                                   |  | -                         | USA                                 | muy:                                   |
|                                     | death<br>ms 2;<br>rmus   | nera             | 11. Marital Status   | 12 Was Decedent Ever  | r in U.S. 13.                  | Was Decedent of H<br>If Yes, specify Cuba     | ispanic Origin?                        | (Specify Yes or N                          |                           | 14. Race - Amer<br>Black, White     |  |
| ۵<br>پو                             | or ite   | by Fu            | 1 Never Married 2 Married  | 1 ☐ Yes 2 XNo<br>If Yes, Give                                     |                                | 1 ☐ Yes 2 XNo                                 | Specify:                               | eno modif, etc./                           |                           | Specify: 3                          | ack                                    |
| Romaine<br>21215-0036               | hours<br>tural"  |                  | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's   | Year or Dates:  | 16a. Dece                      | dent's Usual Occup                            | ation                                  |  | 16b. Kii                  | nd of Business/I                    | ndustry                                |
| 215-0                               | hin 72<br>9.<br>In "na<br>Medic  | plet             | (Specify only highest of Elementary/Secondary (0-12)                               | grade completed)  College (1-4or 5+)                              | ı (Give                        | kind of work done of<br>DO NOT use retired    | during most of v<br>i)                 | vorking                                    | 1                         |                                     | ,                                      |
| R. 21.                              | be filed within 72 hours after death with the Maryland<br>tial Hygjene.<br>d other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at   | Completed        | 12th grade   | ŊĄ  |                                | Disab   |  |  |                           | Disable                             | d<br>                                  |
| سم مع :<br>Maryland                 | be do do   | Be               | 17. Father's Name First, Middle, La  |   |                                |   |  | lame (First, Middle                        | e, Maiden                 | ,                                   |  |
| s a s                               | should be<br>and Mental<br>is marked o   | 우                | Dewey Duns 19a. Informant Name/Relationship  |   | 19b, Mailir                    | ng Address (Street                            |  |  | , –                       |                                     | ip Code) 2117                          |
|                                     | s 1 and 2 should<br>f Health and Mer<br>Item 27 Is marke<br>other traumatic  |                  | Linda Tyrell /   | Sister  | 2014                           | o Huntir                                      | na Rida                                | o Drive                                    | . DWI                     | ings Mi                             | lls, MD                                |
| K2                                  | 0 0  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3                              | 1   |                                | sition (Name of<br>matory or other place      | (e)                                    | Date                                       | 20c. Lo                   | cation - City or 1                  | Town, State                            |
| Rfert km<br>Baltimore,              | t. Pages<br>tment of l<br>tant: If it  |                  | 4 Donation 5 Dother (Spe   | cify)   | Mt. Zior                       | 1 Comete                                      | ry or                                  | H10/08                                     | 130                       | amo                                 | ore, MD                                |
| Afie.<br>Baltir                     | permit. Pag<br>Department<br>Important: I<br>any Injury o  |                  | 21. Signature of Funeral Service Lic   | Inel Mol  | 401                            | 2. Name and Addre                             | evtu Ro                                | ad Ran                                     | dalla                     | reene Hu                            | moval SVC<br>MD 21133                  |
|                                     | MISH I   |                  | 23a. P. rtf. Enter the disease, or co  | mplications that caused the ly one cause on each line.            | death. Do not ent              | ter the mode of dyir                          | ng, sur as card                        | iac or respiratory                         | arrest,                   | 10000                               | Approximate<br>Interval Between        |
| اع                                  | Physician  | П                | Imm of ate Cause (Final disease or condition                                       |   |                                | in faretion                                   |  |  |                           |                                     | Onset and Death                        |
| 7                                   | /Medical<br>Examiner   | П                | resulting in death)  | Due to (or as a co  | onsequence of):                |   |  |  |                           |                                     |  |
|                                     |  | je               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a co   | onsequence of):                |   |  |  |                           |                                     |  |
| V                                   | ecuted<br>nd<br>transit  | Examin           | Cause: Unsease or injury that initiated events resulting in death) Last            | с   |                                |   |  |  |                           |                                     |  |
| 8760,                               | ficate be executed physician and s the burial-transit  | al Ex            | resulting in death) Last   | Due to (or as a co  | onsequence of):                |   |  |  |                           |                                     |  |
| 587                                 | ficate<br>physics the  | edical           |  | d   |                                |   |  |  |                           |                                     |  |
| ŏ                                   | leath certific<br>attending p  | M/u              | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome pf p<br>1 ☐ Live birth 2 ☐                   |                                | ∃Ectopic pregnancy                            | ,                                      |  | 1                         | 23d. Date of deli                   |  |
| Division or Vital Records, P.O. Box | e deat<br>he attu  | Physician/M      | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                  | 4☐Pregnant at time  |                                | Other (specify)                               | <b>'</b>                               |  |                           | Month                               | Day Year                               |
| Ρ.                                  | w requires that the d<br>been signed by the<br>should be detached  | Phy              | Part II. Other significant conditions  | s contributing to death but no                                    | ot resulting in the u          | nderlying cause giv                           | en in Part I.                          | 23e. Did                                   | tobacco u                 | use contribute to                   | the cause of death?                    |
| ds,                                 | uires<br>signe<br>Ild be   | d by             |  |   |                                |   |  | 1 🗆  | Yes 2[                    | □ No 3 Pro                          | obably 4 □Unknown                      |
| OS<br>OS                            | aw rec<br>s bee  | Completed        | D: - 6.  | tension tes Mellitu   |                                |   |  | 24a. Wa                                    |                           | 24b. Were au                        | topsy findings available               |
| R<br>R                              | sician: The law<br>certificate has t<br>lirector, page 2 s   | lmo;             |  |   |                                |   |  | – auto<br>peri<br>1∐ Yes                   | opsy<br>formed?<br>2 No   | death?                              | completion of cause of 2 No            |
| Vita                                | Iclan;<br>sertific<br>ector,   | Be               | 25. Was case referred to medical examiner?   | Hospital:   |                                | 046   |  | Death (Check only                          | one)                      |                                     |  |
| ō                                   | Physic ruthis crall direct   | ٠ <u>۲</u>       | 1 ☐ Yes 2 ☑ No  27. Manner of Death  | 1 ☐ Inpatient 28a. Date of Injury                                 | 2 ER/Outpatier<br>28b. Time o  |   | 4 LJ Nursing                           | g Home 5 ☐ Res<br>28d. Describe            |                           |                                     | cify)                                  |
| on                                  | ndlng<br>th.<br>:: After<br>e fune   | tion             | 1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investigati                                |   |                                | Wor   | k?<br>Yes 2∐No                         | 200. 5000150                               | now injui                 | y obtained                          |  |
| N.S.                                | r Atter<br>er dea<br>rector<br>by th   | Certification:   | 3 Suicide 6 Could not 4 Homicide determine   | be 28e. Place of injury -<br>building, etc. (5                    | At home, farm, str<br>Specify) | reet, factory, office                         |  | 28f. Location<br>City or To                | (Street an                | nd Number or Ru                     | ral Route Number,                      |
| Ö                                   | pital o<br>urs aft<br>aral Di  |                  | 200 Contillor  |   |                                | h conversal state of                          | ma deter to                            |  |                           |                                     | alated                                 |
|                                     | To the Hospital or Attending Physician: The law requires that the death certificathin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical          | 29a. Certifier 1   | Physician: To the best of manner: On the basis of examiner stated | amination and/or in            | n occurred at the til<br>vestigation, in my o | me, date and place<br>opinion, death o | ace, and due to the<br>ccurred at the time | e cause(s)<br>e, date and | ) and manner as<br>d place, and due | to the cause(s)                        |
| _                                   | To th<br>within<br>To th<br>compl  | Me               | 29b. Signature and title of certifier  |   |                                | 29c. Licens                                   | e number                               |  | 29d. Dat                  | te signed (Month                    | n, Day, Year)                          |
|                                     |  |                  |  | M.D.  |                                | Δ5  | 9062                                   |  | A                         | pril 8,                             | 2008                                   |
|                                     | Y  |                  | 30. Name and address of person wh  | o completed cause of death  | (Item 23a) (Type,              | Print)  |  |  |                           |                                     |  |
|                                     | Sta  | ate              | 31. Date filed (Month, Day, Year)  | M.A 246   | Signature                      | elvedere                                      | Dalhr                                  | more MO                                    | 212                       | 13                                  |  |
|                                     | Poniet   | ror              | APRIUM   | III Property  | Mr. Mag                        | 100   |  |  |                           |                                     |  |

DHMH 17 Rev 1/2001

|            |   |                  |   |   |   |                                  |                          |  | Health and N   |   | ene   |  |
|------------|---|------------------|---|---|---|----------------------------------|--------------------------|--|--|---|---|--|
|            |   | •                | 1 - For<br>State<br>Registrar   |   |   |                                  | •                        | tificate o   |  | _   | g. No. 2008                                   | 11659  |
| П          | Physicia  | an               | 1. Decedent's Name (First, Middle,  | Last)                                   |   |                                  |                          |  |  | 2. Date of Death<br>Month                   | 4, 2008 Year                                  | 3. Time of Death                                   |
|            | /Medic  | al               | Evelyn Ellers  4a. Facility Name (If not institution,   |   |   |                                  |                          | 45 City Taylor   | as Leasting of Dooth   |   | 4, 2008<br>4c. County of Deat                 | 8:51 AM M  |
| <i>f</i>   | Examin  | er               | 3650 Keystone   |   | mper)                                   |                                  |                          | •  | or Location of Death imore   |   | 4c. County of Deal                            | u i  |
|            | Funeral   |                  |   | 6. Sex                                  | 7. Age (                                | 'In yrs. last                    | birthday)                | If Under 1 Year<br>Months Day                          | r If Under 24 Hrs.   | 8. Date of Birth<br>(Month, Day,            | year) 9. Birt                                 | hplace (State or Foreign                           |
|            | Director  |                  | 218-01-9797   | 1 ☐ M 2 🔀 F                             | 91                                      | 0                                | Yrs.                     | Months Day   | S Hours Will.  | Dec 28,                                     | 1917 Mary                                     | yland  |
|            | land  |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 1                                       | Oc. City, T                      | own or Loc               | cation   |  |   |   | 10d. Inside City Limits                            |
|            | Mary  | tor              | MD  |   |   | Bal                              | timor                    | e  |  |   |   | 1√2 Yes 2 □ No                                     |
|            | death with the Maryland me 23a or 28a-f ehow  | Funeral Director | 10e. Street and Number<br>3650 Keystone A   | Tropus                                  | ,                                       |                                  |                          | 10f. Zip Code  | 21211  | 10  | g. Citizen of What Co<br>USA                  | ountry?  |
|            | eath v  | eral             | 11. Marital Status  | 12. Was Dec                             | edent Ev                                | er in U.S.                       | 13 V                     | Vas Decedent o   |  | pecify Yes or No-                           | 14. Race - Ame                                | erican Indian.                                     |
|            | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene a few or items 23a or 28a-f show ten 21 is marked other then "netural", or items 23a or 28a-f show other treumatic event, it a Medical Examinar must be notified at | by Fun           | 1 ☐ Never Married 2 ☐ Marrie<br>3 🎇 Widowed 4 ☐ Divorced  | Armed F                                 | orces?<br>2 📉 No<br>ive                 |                                  |                          | Yes, specify Cu ☐ Yes 21 N                             | f Hispanic Origin? (Sp<br>aban, Mexican, Puerto<br>o <i>Specify:</i> | Rican, etc.)                                | Black, Whit                                   |  |
| 21215-0030 | n 72 ho<br>"netur   | Completed        | 15. Decedent'.<br>(Specify only highest   | Education<br>grade completed)           |   | 1                                | 6a. Deced<br>(Give i     | ent's Usual Occ<br>kind of work don<br>OO NOT use reti | upation<br>e during most of work<br>red)                             | king  | 6b. Kind of Business                          | (Industry  |
| 717        | e filed within<br>al Hygiene.<br>I other then "<br>vent, It e Me  | шо               | Elementary/Secondary (0-12)   | College (                               | 1-4or 5+)                               |                                  | _                        | esperso  |  |   | Hecht Co                                      | mnany  |
|            | e filec<br>al Hyg<br>I othe<br>vent,  | BeC              | 17. Father's Name (First, Middle, L   | ast)                                    |   |                                  |                          |  |  | e (First, Middle, M                         |   | mpany  |
| yland      | 2 should be to and Mental I is marked o reumatic eve  | 2                | Anthony Desell  |   |   |                                  |                          |  |  | lizabeth                                    |   |  |
|            | d 2 sh<br>th and<br>the m<br>treum  | - 1              | 19a. Informant's Name/Relationsh<br>evelyn Ellers/e   |   |   | 1                                |                          | -  | et and Number or Rui<br>ne Avenue                                    |   | City or Town, State, 2                        |  |
| <u>ē</u>   | s 1 an<br>f Heal<br>ftem 2<br>other   |                  | 20a. Method of Disposition  |   |   | 20b. Place                       | e of Dispos              | sition (Name of natory or other p                      | Ţ  |   | Oc. Location - City or                        |  |
| Баппо      | permit. Pages 1 and 2<br>Department of Health a<br>Important: if Item 27 is<br>any Injury or other tre  |                  | 1 Burial 2 Cremation 4 Donation 5 Other (Sp   | ecity)                                  | State                                   | Come                             |                          |  |  |   |   |  |
| a<br>D     | Departi<br>Departimbon<br>Impon<br>any Ir   |                  | 21. Signature Funeral Solvice L<br>Ronald S   | ask                                     | ire                                     |                                  | Ва                       | 1timore  | , MD 2120  | 1   | Baltimore                                     | Street   |
| į F        | Physician   |                  | 23a. Part1. Enter the disease, or o<br>shock or heart failure. List o<br>Immediate Cause (Final<br>disease or condition | complications that<br>inly one cause on | caused the each line.                   | ne death. [                      | Do not ente              | er the mode of d                                       | ying, such as cardiac  | or respiratory arre                         | st,   | Approximate<br>Interval Between<br>Onset and Death |
|            | /Medical<br>Examiner  |                  | resulting in death) Sequentially list conditions.   | Due to                                  | or as a d                               | consequen                        | ce of):                  | ia   |  |   |   |  |
| -          | ed<br>Isif  | lner             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to                                  | (or as a                                | consequen                        | ce of):                  |  |  |   |   |  |
| ,00,       | eath certificate be executed<br>eftending physicien and<br>for use as the burial-transif  | cal Examiner     | that initiated events<br>resulting in death) Last   | c. Due to                               | (or as a                                | consequen                        | ce of):                  |  |  |   |   |  |
|            | certificate<br>Iding phy<br>Ise as the  |                  |   | d                                       |   |                                  |                          |  |  |   |   |  |
| Ď          | fhe death cer<br>y the eftendir<br>ached for use  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                 |   | birth 2<br>nant at tir                  | pregnancy<br>Fetal deme of death | ath 3                    | Ectopic pregnar<br>Other (specify)                     | ncy  |   | 23d. Date of de<br>Month                      | livery<br>Day Year                                 |
| ords, r    | sicien: The law requires thet the di<br>certificate has been signed by the<br>rector, page 2 should be detached   | Ď                | Part II. Other significant condition  | e contributing to                       | death but                               | not resultin                     | ng in the un             | nderlying cause  | given in Part I.   |   |   | o the cause of death?                              |
| <u>ဂ</u>   | law rec<br>as beer<br>2 shou  | plete            | Hub   | eldee                                   | 20                                      | n                                |                          |  |  | 24a. Was an                                 | 24b. Were a                                   | utopsy findings available                          |
| I -        | The I   | Completed        | 00  |   |   |                                  |                          |  |  | autopsy<br>perform<br>1 Yes 2               | ed? death?                                    | completion of cause of<br>2 □ No                   |
| <u> </u>   | Physicien:<br>this certific<br>ral director,  | Be               | 25. Was case referred to medical examiner?  | Hospital:                               |   |                                  |                          | 10   | )thor:   | th (Check only one                          |   |  |
| ō          | Phys<br>rthis<br>ral dir  | 5.               | 1 ☐ Yes 2 ☑ No<br>27. Manner o Øeath  | 28a. Date                               | fnpatient<br>of Injury                  |                                  | Outpatient b. Time of    | t 3□ DOA 28c. In                                       | 4 🗀 Nursing H  | ome 5 Aesider<br>28d. Describe how          | nce 6 Other (Spe<br>winjury occurred          | icify)   |
| <u></u>    | Attending r death. ector: After by the fune   | atlor            | 1 Delatural 5 ☐ Pending<br>2 ☐ Accident investig  |   | nth, Day Y                              | Year)                            | Injury                   |  | lork?<br>□Yes 2□No   |   |   |  |
| DIVISION   | al or Atte<br>s efter de<br>si Directo<br>ad in by th   | Certification:   | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determit  | 200. Plac                               | e of Injury<br>ling, etc.               | / - At home<br>(Specify)         | , farm, stre             | eet, factory, offic                                    | е  | 28f. Location (Str.<br>City or Town,        | eet and Number or R.<br>State)                | ural Route Number,                                 |
|            | To the Hospital or Attending Physicien: To the Attending Steries of the Fuores librators. After this certific completely filled in by the funeral director.   | Medical (        | 29a. Certifier 1 Certifying (Check only one)  | xaminer: On the t                       | e best of e<br>pasis of e<br>nner state | xamination                       | dge, death<br>and/or inv | occurred at the<br>restigation, in m                   | time, date and place,<br>opinion, death occur                        | , and due to the ca<br>rred at the time, da | use(s) and manner as<br>te and place, and due | s stated.<br>e to the cause(s)                     |
|            | To th<br>within<br>To th<br>comp  | Ĭ                | 29b. Signature and title of certifier   | Ce be                                   | محا                                     | m                                |                          | 29c. Lice  | nse number   | 29  | d. Date signed (Mont                          | th, Day, Year)                                     |
| •          |   |                  | Peru  |   |   |                                  |                          | D  | 70/10  |   | 2/38/9  | 000  |
|            |   |                  | 30. Name and address of person v  | no completed can                        | of dea                                  | ith (Item 23                     | (Type, I                 | Print) - M   | D 213  | 3(( )                                       |   |  |
|            | Sta   | te               | 31. Date filed (Month, Day, Year)   | 008                                     | Registrar'                              | s Signature                      | Pras                     | E.   |  |   |   |  |
|            | Registr   | ar               | APRIUZ  | UUU AAA                                 | P. Beach                                | Special E                        | -                        | _  |  |   |   |  |

DHMH 17 Rev 1/2001

| Physic  | cian.  | 1 - State Registrar  1. Decedent's Name (First, Middle, Last)   |  | Ezersl   |   | Dealii   | 2. Date of Dea<br>Month   |   | / Year  | 3. Time of Death   |
|---|--|---|--|--|---|--|---|---|---|--|
| /Med<br>Exam  | lical  | 4a. Facility Name (If not institution, give st<br>Manor Care Woodbr   |  |  | 4b. City, Town, or  |  |   |   | 08<br>unty of Death<br>ltimore  | 7 P M  |
| Funera<br>Directo   |  | 5. Social Security Number 6. Sex  |  | rs. last birthday)<br>4 Yrs.   | If Under 1 Year<br>Months Days  |  | Hrs. 8. Date of Birth Min. (Month, Day May 13,  | , Year)   | 9. Birthp<br>Coun<br>Mary]  | lace (State or Foreign<br>try)<br>_and   |
| ne Maryland<br>Ba-f show  | ctor   | 10a. State 10b. County  MD Baltimor   |  | City, Town or Lo   | imore   |  |   |   |   | 0d. Inside City Limits 1 ☐ Yes 2√ No   |
| ath with the 23 a or 2  | Funeral Director   | 8317 Windsor Mill   |  |  | 10f. Zip Code 212   |  |   |   | USA Race - Americ   |  |
| 72 hours after death with the Maryland<br>natural; or itams 23a or 28a-f show<br>iteal Experience restiffed at  | by   | 11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  | <ol> <li>Was Decedent Ever in<br/>Armed Forces?</li> <li>1 ☐ Yes 2 Mo<br/>If Yes, Give<br/>Year or Dates:</li> </ol>   |  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No   | Specify:   | n? (Specify Yes or No-<br>Puerto Rican, etc.)   |   | Black, White,   |  |
| within<br>ane.<br>than "  | Completed  | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | completed)  College (1-4or 5+)   | /Give  | dent's Usual Occup<br>skind of work done of<br>DO NOT use retired   | durina most c  | of working  | 16b. Kind   | of Business/Ind   | dustry   |
| 2 should be filed<br>and Mental Hygis<br>is markad other<br>aumatic evant, II   | To Be Co   | 17. Father's Name (First, Middle, Last) Harry Ezersky   |  |  |   | Ka   | s Name (First, Middle,<br>te Steiner  |   | mame)   |  |
| 1 and<br>1ealth<br>1m 27<br>ther tr   |  | 19a. Informant's Name/Relationship (Type Eileen Schneider/c   | cousin   | 1211   |   | Hill I   | or Rural Route Numbe.<br>Drive Owing  | gs Mil  |   | 21117  |
| t. Pa<br>rtmer<br>rtant.  | i de la companya de l | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)  21. Sign ture of Funeral Syrvice License  Ronald S. W.  | in state   | 23   | 2. Name and Addre   | ss of Facility   | ard 655 W.  | Ro1+-   | imara S   | troot  |
| Physician   |  | Immediate Sause (Final  | e cause on each line.  |  |   |  | ardiac or respiratory arr   |   | 1:  | Approximate<br>Interval Between<br>Onset and Death   |
| /Medica Examine sician and e purial-transit   | Examiner   | Immediate Seuse (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a cons   | sequence of):  |   |  | olio vu su  |   | dien  | Interval Between   |
| death certificate be executed by a standing physician and ador use as the burial-transit  | edlcal Examiner  | disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  LE FEMALE.   | Due to (or as a cons   | sequence of): sequence of): gnancy etal death 3[   |   | c Ca   |   | olm   | Date of deliver   | Interval Between Onset and Death   |
| death certificate be executed be attending physician and bod for use as the burial-transit  | by Physiclan/Medical Examiner  | disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  Consumer to the consumer to  | sequence of):  | □Ectopic pregnancy  | c Ca   | olio vu sa  | 23d   | Month contribute to the   | Interval Between Onset and Death Onset and Dea |
| The law requires that the death certificate be executed by a sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit but  | Completed by Physiclan/Medical Examiner  | disease or condition resulting in death)  Sequentially list conditions. Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions continued to the past 12 months?   | Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  Consumer to the consumer to  | sequence of):  | □Ectopic pregnancy  | ren in Part I.   | 23e. Did to 1 Yes   | 23d abacco use les 2 d an an an an 22 No  | Month  contribute to the state of the state | Interval Between Onset and Death Onset and Dea |
| tanding Physician: The law requires that the death certificate be executed to be a seculed to | To Be Completed by Physiclan/Medical Examiner  | disease or condition resulting in death)  Sequentially list conditions.  Decays of list and list and list are sequentially list and list are sulting in death) Last  C.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1                 | Due to (or as a cons  Constant at time of president at time of presid | gnancy etal death of  | Dectopic pregnancy Other (specify)  underlying cause give  nt 3 DOA  of 28c. Injur Wor M 1                        | en in Part I.  26. Place coer: 4 Murs  | 23e. Did to 1 Y 24a. Was a autop perfor 1 Yes of Death (Check only or 28d. Describe h   | 23d  an 2 2 No  ne)  lence 6 Lency on injury of                                     | Month  contribute to it  3  Prob  4b. Were auto prior to coideath? 1 Yes  Other (Specificourred   | ery Day Year  ne cause of death? habiy 4 Unknown psy findings available mpletion of cause of   |
| or Attanding Physician: The law requires that the death certificate be executed the death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit   | Certification; To Be Completed by Physician/Medical Examiner   | disease or condition resulting in death)  Sequentially list conditions. Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a cons  Consider the cons  Due to (or as a cons  Due | grancy etal death 5 [ resulting in the understand of linjury the home, farm, standing)  converges of the sequence of the seque | Dectopic pregnancy Other (specify)  Int 3 DOA  Other (specify)  And 3 DOA  Other (specify)  Teet, factory, office | 26. Place of the control of the cont | 23e. Did to  1 Yes  24a. Was a autop perfor  1 Yes  of Death (Check only or 28d. Describe hor)  28f. Location (Society or Town)       | 23d  bbacco use fes 2 (a) an 2 ymed? 22 (No ne) dence 6 [ frow injury or ause(s) an | Month  contribute to the state of the state | ery Day Year  Day Year  Day Year  Day 4 Unknown  Day 1 One of cause of 2 No  A Route Number,   |
| uttanding Physician: The law requires that the death certificate be executed to death.  ctor: After this certificate has been signed by the attending physician and to the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.   | To Be Completed by Physiclan/Medical Examiner  | disease or condition resulting in death)  Sequentially list conditions.  B.  Cause (Disease or Injury that initiated events resulting in death) Last  C.  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 | Due to (or as a cons  Bc. If yes, outcome of pre- 1  | grancy etal death 5 [ resulting in the understand of linjury the home, farm, standing)  converges of the sequence of the seque | Dectopic pregnancy Other (specify)  Int 3 DOA  Other (specify)  And 3 DOA  Other (specify)  Teet, factory, office | 26. Place of the state and the state and pointon, death  | 23e. Did to 1 Yes 24a. Was a autop perfor 1 Yes of Death (Check only or ing Home 5 Resid 28d. Describe h 28f. Location (S City or Tow | 23d  23d  23d  22d  22d  22d  22d  2d  2  | Month  contribute to the state of the state | Interval Between Onset and Death Onset and Dea |

|   |                  | - State Amend Item 23a ]  | of Marylai  | nd / Depa<br>8 <b>78,04</b>       | tilicate of   | lealth and N<br>Death                     | Mental Hy                            | giene<br>Reg. No     | .2000                               | 1 11661  |
|---|------------------|---|---|-----------------------------------|---|---|--------------------------------------|----------------------|-------------------------------------|--|
| Physic  | ian              | Decedent's Name (First, Middle, Last)   |   |                                   |   |   | 2. Date of De<br>Month               | Da                   |                                     | 3. Time of Death                                   |
| /Medi<br>Examir   |                  | 4a. Facility Name (If not institution, give street and  | f number)   |                                   | 4b. City, Town, o   | r Location of Death                       | April                                | 40.                  | County of Deat                      |  |
|   |                  | University of Marylan   |   | • • •                             |   | timore                                    |                                      |                      | n/a                                 |  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 1  | _   | . last birthday)<br>9 Yrs.        | If Under 1 Year Months Days                                   | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Bing (Month, Day 6,       | a <i>y, Year)</i>    | 9. Birt                             | chplace (State or Foreign<br>ountry)<br>NC         |
| land ow   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. C  | ity, Town or Lo                   | cation  |   |                                      | -                    |                                     | 10d. Inside City Limits                            |
| e Mary<br>a-f sho<br>ifled a  | ctor             | MD Anne Arundel   | Lau   | ırel                              |   |   |                                      |                      |                                     | 1 □ Yes 21K No                                     |
| vith the  | Dire             | 10e. Street and Number  |   |                                   | 10f. Zip Code   |   |                                      | 10g. Cit             | izen of What Co                     | untry?   |
| leath v<br>ns 23a<br>must   | Funeral Director | 243 Brock Bridge Road  11. Marital Status 12. Was   | Decedent Ever in U  | J.S. 13. 1                        | 2072 Was Decedent of H  |   | pecify Yes or No                     | USA                  | 14. Race - Ame                      | rican Indian,                                      |
| ING 21215-0036  be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ                | Arme 1 Never Married 2 Married 1 Never Married 2 If Yes   | d Forces?<br>es 2∰No<br>, Give<br>or Dates:               |                                   | If Yes, specify Cuba<br>1 ☐ Yes 2[3]No                        | an, Mexican, Puerto                       | o Rican, etc.)                       |                      | Black, White<br>Specify: w          | _  |
| 5-003<br>72 hours<br>"natural",<br>dical Exar   | Completed        | 15. Decedent's Education (Specify only highest grade comple   | 'ed)  | 16a. Dece                         | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of work              | king                                 | 16b. K               | ind of Business/                    | Industry   |
| 2121<br>d within<br>giene.<br>er than '   | dmo              | Elementary/Secondary (0-12) Colle   | ge (1-4or 5+)   | Homema                            | _   | 3)  |                                      | Ow:                  | n Home                              |  |
| nd 21   | Be               | 17. Father's Name (First, Middle, Last)   |   | 1                                 |   | 18. Mother's Nam                          | ne (First, Middle                    | , Maider             | Surname)                            |  |
| Mer Mer   | 2                | Joseph Martin  19a. Informant's Name/Relationship (Type. Print)   |   | 10b Mailie                        | ng Address (Street  |   | e Pernel                             |                      | Ot-1-                               | 7:- 0 - 1 - 1                                      |
|   |                  | James L. Everett, Sr.   |   | I                                 | Brock Bri   |   |                                      | -                    |                                     | zip Code)  |
| Soff  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f                                       | I .   | Place of Dispo<br>cemetery, crei  | sition (Name of<br>matory or other plac                       | e) Apri                                   | Date<br>il 7,<br>008                 | 20c. Lo              | ocation - City or                   | Town, State  |
| Baltimor permit. Pages Department of Important: If ite any Injury or o  |                  | 4 Donation 5 Other (Specify)  |   | -                                 | Cemetery  |   |                                      |                      | rel, MD                             |  |
| Balt permit. Departimonts any Inj   | 1 6              | 21. Signature of Funeral Service Licensee   | M010  |                                   | 2. Name and Addre   |   |                                      |                      |                                     | ne, P.A.   |
|   |                  | 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause       |   | th. Do not ent                    | er the mode of dyir   | ng, such as cardiac                       | or respiratory a                     | arrest,              |                                     | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical   | -                | resulting in death)   | rdiac<br>e to (or as a conse                              | mence of):                        | •   |   |                                      |                      |                                     |  |
| Examiner  |                  | C-  | psis  | quenoe on:                        |   |   |                                      |                      |                                     |  |
| rigi B //   | niner            | Sequentially list conditions, if any, leading to immediate cause. Elefology in Cause (Disease or Injury | e to (or as a conse                                       | quence of):                       |   |   |                                      |                      |                                     |  |
| execuin and rial-trar   | Examiner         | that initiated events c.  | to (or as a conse   | quence of):                       | 141.  |   |                                      |                      |                                     |  |
| cate be executed physician and the burial-transit   | dical            | d   |   |                                   |   |   |                                      |                      |                                     |  |
|   | /Med             |   | , outcome pf pregr  |                                   |   |   |                                      |                      | 23d. Date of del                    | ivery  |
| COIdS, P.O. BOX to require that the death certiful been signed by the attending should be detached for use at   | Physician/Me     | in the past 12 months? 1 ☐ Yes 2 ☐ No   | ive birth 2 ☐ Fet<br>regnant at time of<br>nknown         |                                   | Ectopic pregnancy Other (specify) _                           | /   |                                      |                      | Month                               | Day Year   |
| T.C. that the ed by th detache  | Phy              | 9 ☐ Unknown 9 ☐ Unknown  Part II. Other significant conditions contributing                             |   | sulting in the u                  | nderlying cause giv   | en in Part I.                             | 23e. Did                             | tobacco i            | use contribute to                   | the cause of death?                                |
| HECONGS, P.O. he law requires that the e has been signed by th age 2 should be detache  | d by             | 9   |   |                                   |   |   |                                      |                      | □ No 3□ Pr                          | _  |
| as a co   | Completed        |   |   |                                   |   |   | 24a. Was                             |                      | 24b. Were au                        | utopsy findings available completion of cause of   |
| # %   |                  |   |   |                                   |   |   | perfe<br>1∐ Yes                      | ormed?               | death?                              |  |
| OF VITAL Physician: This certificat ral director, pa  | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 Hospital:   | Inpatient 2   | ER/Outpatien                      | t 3DLDOA Oth  | er: 4 Nursing H                           |                                      |                      | 6 □Other (Spe                       | oif il   |
| on or vital ding Physician; h. After this certifice funeral director,   | <del> </del>     | 27. Manner of Death 28a. D  | ate of Injury Month, Day Year)                            | 28b. Time of Injury               |   |   | 28d. Describe                        |                      |                                     | Спу)   |
| ONISION  or Attending after death. Director: After in by the fune   | icatio           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | lace of injury - At h                                     | nome farm etr                     |   | Yes 2 □ No                                | 29f Lanation                         | (Ctroot or           | ad Number on Di                     | und Bauta Alemaha                                  |
| al or A safter of all Direct  | Certification:   | 4 ☐ Homicide determined   | uilding, etc. (Spec                                       | ify)                              | eet, factory, office  |   | City or To                           | wn, State            | e)                                  | ural Route Number,                                 |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely illed in by the funer   | Medical (        | 29a. Certifier (Check only one) 1 Tertifying Physician: To Medical Examiner: On t and                   | the best of my kn<br>ne basis of examin<br>manner stated. | owledge, deatl<br>ation and/or in | n occurred at the tir<br>vestigation, in my o                 | me, date and place<br>opinion, death occu | , and due to the<br>rred at the time | cause(s<br>, date an | ) and manner as<br>d place, and due | s stated.<br>e to the cause(s)                     |
| Within Void   | Σ                | 29b. Signature and title of certifier   |   |                                   | 29c. Licens   |   |                                      | 29d. Da              | te signed (Mont                     | -  |
|   |                  | 30. Name and address of person who completed  | M D   | m 23a) (Type                      |   | 341                                       |                                      | 7                    | 104/07                              |  |
| 10  |                  | 22 South Greene   | St.   | Ralt                              | more,   | MD 7                                      | 21201                                |                      | 54.00e                              | h. Kossheh   |
| Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year)<br>APR 0 8 2008   | 2. Registrar's Sign                                       | ature A                           | all!  |   |                                      |                      | -                                   |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:10 PM hoebe 03 2003 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizen's Care + Rehab Frederick Center rederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, July 30 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. 1 ☐ M 2 🖾 F Hours Director 214-46-5048 60 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If item 27 le markad other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Washington 1 ☐ Yes 2 € No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 S. Walnut Street #602 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à Specify Specify: White 3 X Widowed 4 □ Divorced Completed of Health and Mental Hygiene. Itam 27 Is marked other than "natur other traumatic avent, It e M. Jic. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Clinton Grove 2 Clara Jeanne Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Monath/daughter 7180 Browns Lane Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If its
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serve Licensee RONALD S. Wald 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 2001 Approximate Interval Between Onset and Death Metarblic breat concer Immediate Cause (Final **Physician** Y BAKS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prechant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. disease Gronav artery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Wasan certificate has autopsy performed Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Tursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \tag{Homicide} within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 4/1/08 00062223 PLAKE ON BO CAWY ID 1967 TJ DLIVE PLEDEUCE MD-21703. State Registrar

| William E   | Edward F   | 1              | - For State   | State                   | of Maryla  | and /                            | -             | ment of                                |                    |                      | Menta               | al Hyg       |                                      | Reg. No                   | 20                                     | 08  | 55     |
|---|--|----------------|---|-------------------------|--|----------------------------------|---------------|--|--------------------|----------------------|---------------------|--------------|--------------------------------------|---------------------------|--|---|--------|
| P<br>Medinal  | hysicia<br>Examir  | n/             | egistrar<br>1. Decedent's Name (First<br>WILL]                                      | Middle,La               | EDWARD   | FRA                              | ZIER          |  |                    |                      |                     |              | Date of Dea<br>Month<br>April 8, 2   | ath<br>Day                | Year                                   | 3. Time of Death<br>1349 hrs                          |        |
| 36  |  |                | 4a. Facility Name (if not in<br>438 Riverside Dr                                    | _                       | ive street and n   | umber)                           |               | 1                                      | b. City, 7<br>Pasa |                      | ocation of          |              |                                      |                           | c. County of Deat                      |   |        |
|   | uneral<br>irector  |                | 5. Social Security Number $219-28-0136$   |                         | Sex<br>M 2 F   | 7. Age                           | (In yrs. last | t birthday)<br>Yrs.                    | Month              | er 1 Year<br>ns Days | If Under<br>Hours   | Min.         | 8. Date of B<br>June                 |                           | Forei                                  | rthplace (State or ign ountry) Marvlat                | nd     |
|   |  |                | Usual Residence of Dece   | ent                     |  |                                  |               |  |                    |                      |                     |              |                                      |                           | 702                                    | 10d. Inside City Lim                                  |        |
|   | ow any   |                | Maryland Ar   |                         | rundel   |                                  | 10c. City, To | own or Locati<br>P                     | on<br>asad         | lena                 |                     |              |                                      |                           |  | 1 Yes 2 XI  | - 1    |
| arvland   | 8a-f sh<br>at onc  | Director       | 10e. Street and Number  |                         |  |                                  |               | -                                      | 10f. Zip           |                      |                     |              |                                      | 10g. Ci                   | tizen of What Co                       | untry?  |        |
| h the N   | 3a or 2  |                | 438 Riversi   | de Di                   |  |                                  |               | 1.2                                    |                    |                      | 122                 | 0.1.0        | ''. Y.                               |                           | U.S.A.                                 | rican Indian, Black,                                  |        |
| D 21215-0036<br>should be filed within 22 hours after death with the Maryland | filt 12 finds area usual with the state yans. than "natural", or items 23a or 28a-f show edical Examiner must be notified at once.   | Fune           | 11. Marital Status  1 Never Married 2  3 Widowed 4                                  |                         | 12. Was De Armed I 1 X Yes ed If Yes, Give Ye  | Forces?                          | _             | If Y                                   | es, speci          |                      | Mexican,            |              | cify Yes or N<br>ican, etc.)         | 10-                       | White, etc.                            | nite  |        |
| er all  | ntural'  | a p            | 15. Decedent's Education  |                         | or Dates:  |                                  | pleted) 1     | 6a. Deceder                            | nt's Usual         | I Occupati           |                     |              |                                      | 16b.                      | Kind of Business                       | Alndustry<br>OMMerce                                  | _      |
| 36<br>in 72 ha  | rages, and a snould no mea when the frages are ment of Health and Mental Hygene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.  | ompleted       | Elementary/Secondary  | (0-12)                  | College<br>4   | (1-4 or 5                        | +)            | 9                                      | gine               |                      | DONOT               | ise retire   | u)                                   | Τe                        | lecommu                                | nications   |        |
| 5-0036  | 5 5 5 5  | S              | 17. Father's Name (First,   |                         |  |                                  | 1_            |  |                    | 1                    |                     |              |                                      |                           | n Surname)                             |   |        |
| 2121!<br>"Id be fil   | Mental Hygien<br>marked other<br>c event, the Mi   | o Be           | William  19a. Informant's Name/Re   | Edv                     |  | razi                             | er            | 19b. Mailine                           | a Addres           | s (Street            | Anı<br>and Numl     |              |                                      | ley                       | City or Town, Sta                      | te, Zip Code)   | $\neg$ |
| MD 2  | 27 is n  | ř              | Mark A. Fra   |                         | (Son)  | )                                |               | _                                      | •                  | •                    |                     |              |                                      | . Ma                      | rvland 2                               | 21875   |        |
|   | perinn. rages I and 2 should be tilted with Department of Health and Mental Hygis important: If item 27 is marked other injury or other traumatic event, the L   |                | 20a. Method of Disposition  |                         | Removal  | from Sta                         |               | ace of Disposematory or ot View C      |                    |                      | · 1                 |              | Date                                 | 1                         | . Location - City                      |   |        |
| Baltimore,  | tment c<br>rtant:<br>y or oth  | -              | 4 Donation 5 C  | ther Speci              | fy:  |                                  | Бау           | /                                      |                    |                      |                     | 04-1         |                                      |                           |  | , Maryland  | _      |
| Bal   | Departi<br>Import<br>injury  |                | 21. Signature of Funeral  | Service Lie             | Y V  | nn                               | M             | / Mc<br>32                             | Cu11<br>04 M       | y≌Po.<br>lounta      | lynia<br>ain R      | k Fu<br>oad, | neral<br>Pasad                       | Hom<br>lena               | e P.A.<br>Maryla                       | and 21122   |        |
| _   | ysician  |                | 3a. Part I. Enter the dise  | ase, or cor<br>cause on | nolications that   | caused                           | the death. I  | Do not enter t                         | the mode           | of dying,            | such as ca          | rdiac or I   | respiratory a                        | arrest, s                 | hock, or heart                         | Approximate Inter<br>Between Onset a                  |        |
| P.  | ledical<br>aminer  | 4              | Immediate Cause (Final or condition resulting in o                                  | isease                  | Due to (or as  |                                  |               |  |                    |                      |                     |              |                                      |                           |  | Death   | -1     |
|   |  |                | Sequentially list condition   |                         | b  |                                  |               |  |                    |                      |                     |              |                                      |                           |  |   |        |
|   |  | Examiner       | if any, leading to immedia<br>cause. Enter Underlying<br>(Disease or injury that in | Causc                   | Due to (or as  |                                  |               |  |                    |                      |                     |              |                                      |                           |  | d .   |        |
| ·V  | and<br>transit   |                | events resulting in death   |                         | Due to (or as  | a conse                          | equence of):  | :                                      |                    |                      |                     |              |                                      |                           |  |   |        |
| ,   | cian rial  | dical          | UNPENDED  |                         | AMENDE   | )                                |               |  |                    |                      |                     |              |                                      |                           |  |   |        |
| 68760   | leath certificate of<br>e attending physi<br>for use as the bu   | <b>P</b> I     | IF FEMALE:<br>23b. Was decedent pregr   | ant in the              |  | s, outcon                        | ne of pregna  |  | etal deati         | h 3                  | Ectopic             | pregnan      | псу                                  | -                         | 23d. Date of deliv<br>Month            | ery<br>Day Year                                       |        |
| Box 6   | atn cerr<br>attendir<br>or use a   | Physician/M    | past 12 months?  1 Yes 2 No 9   | Unkno                   |  | -                                | time of dea   | th =                                   | ther (Sp           |                      |                     |              |                                      |                           |  |   | 3      |
| O.  | by the   | Phy            | Part II. Other significan   |                         | 9011   | nown<br>to death                 | but not res   | sulting in the                         | underlyir          | ng cause g           | given in Pa         | ırt 1.       | 23e. Di                              | d tobac                   | co use contribute                      | to the cause of death?                                | ?      |
| Р.  | ires that the de<br>signed by the<br>d be detached f   | d by           |   |                         |  |                                  |               |  |                    | _                    |                     |              |                                      |                           |  | robably 4 Unknow                                      |        |
| of Vital Records,   | aw requir<br>nas been s<br>2 should  | Completed      |   |                         |  | _                                |               |  |                    |                      |                     |              |                                      | as an<br>topsy<br>rformed | prior                                  | autopsy findings avail<br>to completion of cause<br>? | of     |
| Rec   | cran: The ra<br>certificate h<br>ector, page 2   | Som            |   |                         | ,  |                                  |               |  |                    | 26 Pleas             | of Death            | (Charles     | 1 ✔ Ye                               | s 2                       |  |   | 0      |
| /ital   | hysician:<br>this certi<br>I director  | o Be           | 25. Was case referred to examiner?  1 ✓ Yes 2                                       |                         | Hospital: 1  | Inpatie                          | ent 2 🔝 I     | ER/Outpatier                           | nt 3               | DOA DOA              | Other <sub>4</sub>  |              | Home 5                               | Res                       | idence 6 🗸 Ot                          | her: Scene  |        |
| n of \  | nding Phy<br>th.<br>: After tl<br>e funeral  | -1             | 27. Manner of Death  1 Natural 5  | Pending                 | , FOUR   | ite of Inju<br>nth, Day,Y<br>ID: | iry<br>'ear)  | 28b. Time of FOUND:                    | Injury             |                      | ry at Work<br>Yes 2 | . (          | 28d. Descri<br>Subject s             |                           | injury occurred                        |   |        |
| Division  | Hospital or Attend<br>24 hours after death<br>Funeral Director:<br>stely filled in by the  | Certification: | 2 Accident 3 Suicide 6  | Investig<br>Could r     | pation Apr 8,<br>28e. Pl   | ace of In                        |               | 1349 hrs<br>me, farm, stre<br>ily Home | eet, facto         | ory, office t        | ouilding, et        | ic.          | 28f. Locatio<br>or Tow<br>138 Rivers | n (Streen, State          | et and Number or<br>)<br>ve, Pasadena, | Rural Route Number,                                   | City   |
|   | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b |                | 4 Homicide  29a. Certifier 1 Cert (Check only one) 2 Med                            | fying Phys              | sician: To the b   | est of m                         | y knowledg    | e, death occi                          | urred at t         | he time, d           | ate and pla         | ace, and     | due to the o                         | ause(s)                   | and manner as s                        | tated.  |        |
|   | To the<br>To the<br>comple   | Medical        | 29b. Signature and title  | f certifier             | and manne  |                                  |               |  | 2                  | gc. Licens           | se number           |              |                                      | 29                        | d. Date signed (                       | Month, Day, Year)                                     |        |
|   |  |                | high  | <i>ii</i> ,             | nt   |                                  |               |  |                    | O.C.                 | M.É.                |              |                                      | Α                         | pril 9, 2008                           |   |        |
| 1   | 041  |                | 30. Name and address of Ling Li, MD A   |                         | no completed Com |                                  |               | <sup>23a)</sup><br>Penn Stre           | et, Bal            | Itimore,             | MD 212              | 201          |                                      |                           |  |   |        |
|   |  | tate           | 31. Date filed (Month, Da   |                         |  | Registra                         | ır's Signatuı | re                                     |                    |                      |                     |              |                                      |                           |  |   |        |
| рнмн  | Regis  |                | APR   | 107                     | 2008   |                                  | J. 18         | ORIGIN                                 | AL                 |                      |                     |              |                                      | OGN                       | 4E                                     |   |        |

Registrar

State

30. Name and add

31. Date filed (Month, Day,

ess of p

APR

Year)

1.0

2008

Main

rson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE 9a, perfit, \$8/8,4/10/08, WS
State of Maryland / Department of Health and Mental Hygiene
amend #7&8 per FH G878 4/24/08 III

Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death 2:45 RM **Physician** Month /Medical 4a Facility Name (If not institution, give street City, Town, or Location of Death 4c. County of Death Examiner WD altimore aux 5. Social Security Number Under 1 Year If Under 24 Hrs. Decte 30th 1923 Birthplace (State or Foreign Country) last birthday) **Funeral** Hours 1 □ M 2 😿 F 84 Vrs NORTH CAROLINA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Nes 2 No Directo MARYLAND 10e. Street and Number 10g. Chizen of What Country? 10f. Zip Code 14. Race - American Inc Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced BLACK Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 + HORADE and Mental Hygiene. Is marked other than College (1-4or 5+) MAKER MD. SPECIALTY WINE CO. Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event once. Be UMMER ၉ *tugits* 19a Informant's Name/Relationship (Type. Print)
Eleanor
LIANOR IFILL (()) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) HOLLV 51: Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State E-METERY 04-10-08 BALTHORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Agility BROWN TO SEP N. FULTON AVE. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vascular Disease **Physician** Hherosclerotic Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknow signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Completed +090+ 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed: certificate Vital 1□ Yes 2) No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2ØNo 2EFER/Outpatient 3 □ DOA Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury n 24 hours after death.
he Funeral Oirector: A pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapmer stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 5, 2008 0053312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Henggeler, MD 900 Ca 900 caton avenue, Baltimore Mo 2. Registrar's Signature State Good Registrar

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 29, 2008 11:20 PM Faris 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number)

**Physician** /Medical Examiner

Fleanor

Prince Georges Greenbelt 22 Ridge Road If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1□M 2₩F Pennsylvania Director July 3, 1917 579-07-6381 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at Prince Georges 1 ☐ Yes 2 ☑ No Maryland Greenbelt Director 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number USA 20770 22 Ridge Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, GiveXX 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Shultz William Baron Stark 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4500 Tonquil St., Beltsville, MD 20705 Doris Jean Faris - daughter 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 04/05/2008 Brentwood, Maryland Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleck Funeral Home, INC. M0/2 7601 Sandy Spring Road, Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a Cardiovasculor Disease Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner Hxpertension ng physician and as the burial-transit Due to (or as e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of) attending | signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown Macrocytic Anemia, Osteoporosis, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? Degenerative Arthritis, Hemorrhoids. 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No diractor, Hospital or Attanding Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this
filled in by the funeral di 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D31001 30. Name end address of person who completed cruse of death (Item 23e) (Type, Print) 7500 6-een way Cnyr.

**DHMH 16 Rev 6/95** 

State Registrar Green bell, MD

MD

32. Registrer's Signature

12,

lurkewi

|   |  |                 | For<br>State<br>Registrar  | State of Maryla  | -                                 | artment of I<br><i>rtificate of</i>                           |  | Mental Hy                                | giene<br>Reg. No. 2                                  | 08   | 11667   |
|---|--|-----------------|--|--|-----------------------------------|---|--|--|--|--|---|
| F   | Physici<br>/Medic  |                 | Decedent's Name (First, Middle, Lass     SORRELL   | t)   | FRAN                              | K   |  | 2. Date of De                            | _  | ď8ªr   | 3. Time of Death 9:30 A M                     |
|   | Examir   |                 | 4a. Facility Name (If not institution, give<br>HOSPICE OF BALT)  |  | ST CTR.                           | 4b. City, Town, o   | or Location of Death                     |  | 4c. County of BALTII                                 |  |   |
|   | uneral<br>rector   |                 | L13-34-10/3  | 7. Age (In yrs   | i. last birthday)<br>Yrs.         | If Under 1 Year<br>Months Days                                | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Bir (Month, Date 11/15/       | 1934   | 9. Birthplac<br>Country                      | e (State or Foreign                           |
| Aaryland  | f show   | ō               | Usual Residence of Decedent  10a. State 10b. County  MD N/A  | 10c. C   | BALTIM                            |   |  |  |  | 10d.   | . Inside City Limits 1 N Yes 2 No             |
| with the !  | a or 28a-<br>Lberrottif  | Director        | 10e. Street and Number 7033 WALLIS AVEN  |  | DILITI                            | 10f. Zip Code   | 215                                      |  | 10g. Citizen of W                                    | hat Country                                  |   |
| <b>5-0036</b><br>72 hours after death with the Maryland   | d other than "natural", or items 23a or 28a-f show<br>event, it e Medical Examirar must be radified at     | by Funeral      | 11. Marital Status  1 Never Married 2 Married 3 Wildowed 4 Divorced  | 12. Was Decedent Ever in L<br>Armed Forces?<br>1 ☐ Yes 2 MNo<br>If Yes, Give<br>Year or Dates; |                                   |   | Hispanic Origin? (Span, Mexican, Puerto  | pecify Yes or No<br>Rican, etc.)         | USA 14. Race Black Specify:                          | - American<br>, White, etc.                  |   |
| 121<br>vithin   | r than "natura<br>If e Medical E   | Completed       | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | ucation  | 16a. Dece<br>(Give<br>life.       | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | pation<br>during most of work<br>d)      | ing                                      | 16b. Kind of Bus                                     | iness/Indus                                  | try   |
| Maryland 2<br>d 2 should be filed v<br>th and Mental Hygid  |  | To Be C         | 17. Father's Name (First, Middle, Last)  ISADORE   |  | FRANK                             |   | 18. Mother's Name                        |  | Maiden Surname                                       |  |   |
| and 2 should I  | 7 Is<br>trau   | F               | 19a. Informant's Name/Relationship (7) ROCHELLE FRANK  | , ,  | 19b. Mailir                       |   | and Number or Run<br>ROAD, BAL           | al Route Numb                            | er, City or Town, S                                  | State, Zip Co                                |   |
| STa   | = 0  |                 | 20a. Method of Disposition 1   | 20b.   | Place of Dispo<br>cemetery, crer  | sition (Name of<br>natory or other place                      |  | Date                                     | 20c. Location - C                                    | City or Town,                                | ·   |
| balt<br>permit.<br>Departr  | Important; If<br>any injury or<br>once.  |                 | 21. Sign tun of Funeral Service Licen  | ee   | 22                                | 2. Name and Addre   |  | DL LEVI                                  | NSON & BF  | ROS.,  | INC.  |
|   | ician<br>dical<br>niner  |                 | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  | a. Due to (or as a consect   | th. Do not ent                    | er the mode of dyir   | ng, such as cardiac                      | or respiratory a                         | rrest,   | Ap<br>int<br>Or                              | proximate<br>terval Between<br>nset and Death |
| the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. | j pnysician and<br>s the burial-transit  | edical Examiner | Sequentially list conditions, leave the sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consect.   |                                   |   |  |  |  |  |   |
| the death certif  | oner une seruncare has been signed by the attending funeral director, page 2 should be detached for use as | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pregn.  1 Live birth 2 Feta 4 Pregnant at time of 6                    | al death 3 🗆                      | Bectopic pregnancy<br>Other (specify)                         | у  |  | 23d. Date<br>Mont                                    | of delivery<br>h Day                         | y Year  |
| equires tha   | ould be det  | ρ               | Part II. Other significant conditions co   | ntributing to death but not res  | ulting in the ur                  | derlying cause give   | en in Part I.                            |  | obacco use contrib<br>es 2 No 3                      |  |   |
| n: The law r  | nt, page 2 sh  | Completed       | OF Was assessed as a state of the state of t |  |                                   |   |  | 24a. Was a<br>autop<br>perfor<br>1 □ Yes | sy pri-<br>med2 de:                                  | ere autopsy<br>or to comple<br>ath?<br>Yes 2 | findings available etion of cause of          |
| Physicia  | ral directo  | 80  <br> -      | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  | lospital: 1   Inpatient 2   28a. Date of Injury  | ER/Outpatien                      |   | 4 ☐ Nursing Hor                          | me 5 🗆 Resid                             | lence 6 Other  |  | tospice                                       |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After                                | ed in by the fune  | Certification:  | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specif                        | Injury<br>ome, farm, stre         |   | Yes 2□No                                 |  | ow injury occurred<br>street and Number<br>n, State) |  | oute Number,                                  |
| he Hospit<br>in 24 hour<br>he Funera  | pletely fille  |                 | 29a. Certifier 1   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.            | wledge, death<br>ition and/or inv | occurred at the ting<br>estigation, in my o                   | ne, date and place, pinion, death occurr | and due to the ded at the time, d        | cause(s) and mani<br>date and place, an              | ner as state<br>d due to the                 | d.<br>cause(s)                                |
| To t  | Eoo  |                 | 29b. Signature and title of certifier  | Milyns   |                                   | 29c. License  | number 2005                              | 2  | 29d. Date signed (                                   | Month, Day,                                  | Year)   |
|   |  |                 | 30. Name and address of person who co  | mpleted cause of death (Item<br>S B ( 670)   | 1 23a) (Type, F                   | hales   | St. Ba                                   | lto. v                                   | nd 21  | 704  | ¢   |
| R   | Stat<br>egistra  |                 | APR 1 0 2008   | 2. Registrar's Sign  | ture Span                         | W   |  |  |  |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Frances Helen Gray 2008 APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Mar. | 26, WASHINGTON MEDICAL CENTER BALTIMORE HRUNDEL 9. Birthplace (State Country) Maryland Social Security Number . Age (In yrs. last birthday) **Funeral** . 1932 1 □ M 2 F 76 Director 216-28-8696 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No MD Anne Arundel Funeral Director Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 14 Ferdinand Avenue 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SRAY, TRANCES Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be tall Frank C. Gugliotta ၉ Helen S. Heaps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trae Anne Marie Gray - Daughter 239 Turnwood Drive, Glen Burnie, MD 21061 Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State MD Veterans Cemetery Burial 2 Cremation 3 Removal from State 4-11-2008 Crownsville, MD 4 Donation 5 ☐ Other (Specify) @ Crownsville 21. September of Fundral Se 22. Name and Address of Facility Ambrose Funeral Flome, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) P.O. | signed by the a d be detached f JYes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performe 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera Certification: Injury at Work? After 1 🗹 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, To the Hospital within 24 hours at To the Funeral D

DHMH 17 Rev 1/2001

4 Homicide

(Check only one)

BA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CDMO14

APR 1 0 2008

29a. Certifier

Medical

State Registrar and manner stated.

ASWING NOT

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MIDICITA

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** David F. Gearhart 2, April 2008 /Medical 2:41 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Blakehurst** Towson Baltimore If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 🕅 M 2□ F Months Director 170-22-3926 84 May 15, 1923 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, if we Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road #333 21204 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clergyman religion 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Benjamin Gearhart Helen Rena Foster ဥ 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriett Gearhart/spouse 1055 W. Joppa Road #333 Towson, MD 21204 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal Licensee S, Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Lel nec Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Atherselevatic cardiovascular discore Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): by Physician/Medicai resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No moseus 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2□No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) April 02, 200 4 Hered Ballimore Ma 21204 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 6701 Commic MA N Charles

State Registrar

31. Date filed (Month, Day, Yeer) APR 1 0 2008

attending physician and for use as the burial-transit

the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Baltimore, Maryland 21215-0020

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2003 Apri 0207 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GN Baltimore
If Under 1 Year | If Under 2 If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Hours 1 □ M 2 K□ F 220-14-1260 Director YAKCH 25, 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mcdical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits **Funeral Director** 14 Yes 2 □ No TIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5P0U50 10585 CARCINER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 ☐Removal from State DWINGS 192115 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extrinsic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Imone Due to for as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by in by the funeral director, page 2 should be 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Feshen 31. Date filed (Month, Day, Year, Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For

|   |                    | <ul><li>State<br/>Registrar</li></ul>  |  |   | Certificate of   | Death   | F  | leg. No.   | 00  |  |
|---|--------------------|--|--|---|--|---|--|--|---|--|
| Physicia<br>/Medic  |                    | 1. Decedent's Name (First, Mid   |  | Louise Hall   |  |   | 2. Date of Dea<br>Month  | pr 6, 2008   | Year  | 3. Time of Deat<br>10:22 A                                     |
| Examin  |                    | 4a. Facility Name (If not institu  | tion, give street and number 6 Woodstock F   |   | 4b. City, Town,  | or Location of Deat<br>Woodstoc   |  | 4c. County   |   | ward   |
| Funeral<br>Director   |                    | 5. Social Security Number <b>275-24-5381</b>   | 6. Sex<br>1 □ M 2 F  | 7. Age (In yrs. last bir<br><b>80</b>   | Yrs. If Under 1 Yea<br>Months Days                                       |   | (Month, Day  | Year)<br>9, 1927   | 9. Birthpi<br>Coun  | lace (State or Foretry) <b>Ky</b>                              |
| show  | or                 | Usual Residence of Decedent  10a. State 10b. Cour  MD  | nty<br>Howard  | 10c. City, Town   | n or Location  | Woodstoo  | :k   |  | 1   | 0d. Inside City Lir  |
| a or 28a-f<br>be notifi   | Director           | 10e. Street and Number 1476 Woodstock  |  |   | 10f. Zip Code  | 21163   |  | 10g. Citizen of W  | Vhat Coun   | •  |
| natural", or items 23a or 28a-f show<br>dical Examiner must be notifiled at | by Funeral         | 11. Marital Status  1 □ Never Married 2 □ M  3 ■ Widowed 4 □ Divorce   | 12. Was Dec<br>Armed Fo<br>1 1 Yes   | ve T  | 13. Was Decedent of If Yes, specify Cu                                   | Hispanic Origin? (S<br>ban, Mexican, Puer   | Specify Yes or No-<br>to Rican, etc.)  | 14. Race<br>Black<br>Specify:  | e - Americ<br>k, White,<br>: <b>Wh</b> i                                    | etc.   |
| ie.<br>ian "natural",<br>M.dical Exa  | Completed          | 15. Deced<br>(Specify only hig<br>Elementary/Secondary (0-12   | dent's Education<br>thest grade completed)  2) College (   |   | Decedent's Usual Occ<br>(Give kind of work don<br>life. DO NOT use retii | e during most of wo<br>red)   | rking  | 16b. Kind of Bu  | siness/Ind  | ,  |
| and Mental Hygiene. Is marked other than "natu aumatic event, th. M-dical   | Be Con             | 17. Father's Name (First, Midd   | ,  |   | Ho   | memaker  18. Mother's Na  | me (First, Middle,   | Maiden Surnam  | e)  |  |
| Men   | 6                  |  |  | tephenson   |  |   |  | ene Egert  |   |  |
| #2.F  |                    | 19a. Informant's Name/Relation  Mary Peters Da   |  | 196   | Mailing Address (Stree<br>6215 Cutsail A                                 |   |  | -  | State, Zip  | Code)  |
|   |                    | 20a. Method of Disposition  Burial 2 □ Crematic  4 □ Donation 5 □ Other  |  | State cemete  | f Disposition (Name of<br>ry, crematory or other p<br>d Shepherd Cem     | i i   | Date<br>or 09, 2008  | 20c. Location -  | _   | wn, State<br>, Maryland  |
| Department of Important: If any injury or once.                             |                    | 21. Signature of Funeral Serv  | ice Licensee   | 440293  | 22. Name and Add<br>Slack<br>3871 C                                      | ress of Facility<br>Funeral Home<br>Old Columbia F                                  | P.A.<br>like Ellicott C  | ity, MD 2104   | 43  |  |
| hysician<br>/Medical<br>xaminer   |                    | 23a. Part1. Effer the disk se<br>shock, or heart failur. I<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | a  |   | DIAC   |   |  |  | ings  | Approximate Interval Betwee Onset and Deat MINUTS              |
| ding physician and se as the burial-transit                                 | ical Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imittated events resulting in death) Last   | <b>5</b>   | (or as a consequence  | of):   | 0010  |  |  | mei   |  |
| nding<br>Ise at   | Physician/Medical  | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 1 ☐ Live   | tcome pf pregnancy<br>birth 2 □ Fetal death<br>nant at time of death<br>lown                          | 3 □Ectopic pregnar<br>5 □ Other (specify)                                | псу   |  | 23d. Dati  | te of delive  | ery<br>Day Yea   |
|   | 급                  |  |  |   |  |   |  |  | ribute to th  | an anuma of door   |
| n signed b  | þ                  | Part II. Other significant cond  | ditions contributing to d  | eath but not resulting in   | n the underlying cause (   | jiven in Part I.  |  | es 2 No  |   |  |
| te has been signed by the angle 2 should be detached                        | þ                  | Part II. Other significant cond  | ditions contributing to d  | eath but not resulting i  | n the underlying cause (   | jiven in Part I.  | 1 🗆 \  | rmed?  | 3 Prob  | psy findings avaimpletion of cause                             |
| is certificate has  | Be Completed by    | Part II. Other significant cond  25. Was case referred to med examiner?  1 □ Yes 2☑ HO   | ical Hospital  | eath but not resulting in   |  |   | 24a. Was autop perfo   | rmed?  | 3 ☐ Prob<br>Were auto<br>prior to con<br>death?<br>I ☐ Yes                  | pably 4 Unkr<br>psy findings avai<br>mpletion of cause<br>2 No |
| After this certifica<br>funeral director, p                                 | To Be Completed by | 25. Was case referred to med examiner? 1 Yes 22 Ho  27. Manner of Death 1 Natural 5 Per investigation investigatio | Hospital: 1  | Inpatient 2 □ ER/Ou<br>of Injury<br>tth, Day Year) 28b.   | utpatient 3 DOA C  | 26. Place of De ther: 4 ☐ Nursing ury at ork? ☐ Yes 2 ☐ No                          | 24a. Was autor performent of the control of the con | an 24b. Vesy 2 2 3 4b. Vesy 2 3 4b. Vesy 2 3 4b. Vesy 2 3 4b. Vesy | 3 ☐ Prob<br>Were auto<br>prior to con<br>death?<br>I ☐ Yes<br>er (Specified | pably 4 Unkr<br>psy findings ava<br>mpletion of cause<br>2 No  |
| r death.<br>ector: After this certifica<br>by the funeral director, p       | Be Completed by    | 25. Was case referred to med examiner?  1 Yes 2 2 Ho  27. Manner of Death  1 Natural 5 Per invention of the control of the con | Hospital: 1  28a. Date (Mor stigation ald not be ermined 28e. Place build 28d. Place and part of the cal Examiner: On the build 28d. Place bui | Inpatient 2 ER/Ou of Injury 28b. inth. Day Year) 28b. in a of injury - At home, faing, etc. (Specify) | itpatient 3 DOA Continuity M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1         | 26. Place of De ther: 4 \sum \text{Nursing} ury at ork? \sum Yes 2 \sum \text{No} e | 24a. Was autop performent of the control of the con | an 24b. Visy med? 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 3 Prob  | pably 4 Unkripsy findings avain pletion of cause 2 No          |

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Registrar

To the Hospital or Attending Physician: Funeral

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le EASTERN AVENUE 4940 MD Mo て State 2008 Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 25 per Dr. g878 4/10 Gertificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 23, 2008 /Medical c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TIMORE 8. Date of Birth (Month, Day, Feb 21, 9. Birthplace (State or Foreign **Funeral** Min. 2008 Maryland Director none Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1▼Yes 2□No MD Baltimore Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 1824 Walbrook Avenue 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) r than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event: the IM none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Wendy Hicks ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signature of Fineral Service Livens wade, Director 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** matur /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar and Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending IF FEMALE nse ( If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death o the 9□Unknown 9 Unknown signed by the ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 21 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? /es 2 \ No certificate 1∐ Yes Division or Vital Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Ь To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22,2008

State Registrar

DHMH 17 Rev 1/2001

ap mit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

Mobolan tamui

29 S. Greene Street as B110 ballimorE MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 24a,26 per Dr. g878 Cet Micates of Reath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** girl 'B' basy 8.SOAM 02 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimou MO
If Under 1 Year | If Under 24 Hrs. University of Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Director none 52 Feb 21, 2008 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marian III. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD 1√Yes 2□No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1824 Walbrook Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Wnedv Hicks ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Green Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5\\\Q\ther(Specify) in state 21. Signature of Funeral School ade, Director State Anatomy Board 655 W. B

Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final Dis 1255 sociation **Physician** Sindione ld disease or conditior resulting in death) /Medical Due to or as a consequence of): Examiner Extreme Prematuriti 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No s after death. 1 ☐ Yes 2 ☐ No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No M☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending (Month, Day Year) Injury investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ò within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Rm 65110 Baltimore Marie MD 1scarely 29 31. Date filed (Month, Day, Year) APR 1 0 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

BERTE CO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 6. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 Barbara Ann Hook April 8, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sykesville Transitions Healthcare Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Mar. 13, 1 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M XXF 219-34-4362 Yrs 71 1937 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Carroll Manchester 10f. Zip Code 10g. Citizen of What Country United States 10e. Street and Number 2239 Ebbvale Road 21102 America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**/C**No Specify: Specify: ģ 3XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freeman Reeves Edna Wilson ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Noyes (Daughter) 2239 Ebbvale Road, Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview Memorial
Park April 11, 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation S □ Other (Specify) 2008 Sykesville, Maryland 21 Signature of Funeral Service Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Rant/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Jath line. Imm late Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-trans and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 1 Tyes Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:25 P. M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

Westminster MO 2115

1XXYes 2 □ No

Birthplace (State or Foreign Country)

Maryland

White

Division or Vital Records, P.O. Box 68760 certificate has been si rector, page 2 should this funeral

Hospital or Attending Physician: within 24 hours arter control to the Funeral Director; Aff

Be

ို

Certification:

Medical

24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 3□ DOA 1 🖺 Yes 20 No 1 Inpatient 2 ER/Outpatient 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29b. Signature and title of certifie 29c. License number 29d. Date signed/(Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

State 2008 Registrar

**ORIGINAL** 

|                                |  |                | State of Maryland / Department / Depart | artment of Hi<br>3,04/10/08                              | eaith and N<br>Idhb<br>eath          | lental Hygi                          | ene                                     | 11676                                      |
|--------------------------------|--|----------------|--|--|--------------------------------------|--------------------------------------|---|--|
|                                |  |                | Decedent's Name (First, Middle, Last)  |  |                                      | 2. Date of Death                     | 1                                       | 3. Time of Death                           |
| П                              | Physicia<br>/Medic   | _              | Ann Harryman:  |  |                                      | Month<br>MARCH                       | 20, 2008                                | 5. A. M                                    |
| a a                            | Examin   | 40             | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or                                       | Location of Death                    |                                      | 4c. County of Death                     | 1  |
|                                | allerin karan dan palami anang ta  | 18.            | Long Green Center  | Baltimon   |                                      | 0.0                                  | l a Bin                                 | (0)  |
|                                | Funeral  |                | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Yrs.   | Months Days  | Hours Min.                           | 8. Date of Birth (Month Bay, Oct 23, | 1930 Mary                               | place (State or Foreign<br>Intry)<br>'Land |
|                                | Director   | 1              | 212-26-6732 // Yrs.  | <u> </u>   |                                      |                                      |   |  |
|                                | yland<br><b>vow</b><br>at  |                | 10a. State 10b. County 10c. City, Town or Lo   | ocation  |                                      |                                      |   | 10d. Inside City Limits                    |
|                                | e Mar<br>ta-f sl   | cto            | MD Baltin  | nore   |                                      |                                      |   | 1X Yes 2 No                                |
|                                | filed within 72 hours after death with the Maryland<br>Hygiene.<br>wther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notitled at   | al Director    | 10e. Street and Number 5862 Belair Road  | 10f. Zip Code  | 21206                                | 10                                   | og. Citizen of What Cou<br>USA          | untry?                                     |
| <b>.</b>                       | fter deat<br>r items ?<br>ilner mu   | Funeral        | Armed Forces? I  | Was Decedent of His<br>If Yes, specify Cubar             | n, Mexican, Puerto                   | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Amer<br>Black, White         |  |
| -003                           | hours a<br>stural', o  | ed by          | 3 ∆ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent 16a.   | dent's Usual Occupa                                      |                                      |                                      | Specify: W                              |  |
| 1215                           | within 72<br>ene.<br>than "ne<br>ne Medic  | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | kind of work done do<br>DO NOT use retired)<br>eamstress | uring most of work                   | sing                                 | cloth                                   |  |
| d<br>2                         | filed<br>Hygie<br>Sther  | ပ္တို          | 17. Father's Name ( <i>First, Middle, Last</i> )   |  | 18. Mother's Nam                     | e (First, Middle, N                  |   | illig                                      |
| an                             | lid be<br>lental<br>rked c   | To Be          | Joseph Unkle   |  | Dore                                 | othy Silv                            | ores                                    |  |
| ary                            | shou<br>and N<br>s mar   |                | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailir   | ng Address (Street a                                     | nd Number or Rui                     | ral Route Number,                    | City or Town, State, Z                  | ip Code)                                   |
| Σ                              | and 2  |                | Steve Harryman/son 5862  | Belair Ro  | oad Balti                            | imore, MI                            | 21206                                   |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)  | osition (Name of matory or other place                   |                                      | Date                                 | 20c. Location - City or T               | Town, State                                |
| Balti                          | permit. Departm Importa any inju   |                | 21. Signature of Funeral Service Livensee Wave Director St   | 2. Name and Address<br>ate Anato<br>altimore,            | s of Facility<br>my Board<br>MD 2120 | 655 W.                               | Baltimore                               | Street                                     |
| H                              |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.   |  |                                      |                                      | est,                                    | Approximate<br>Interval Between            |
|                                | Physician /  |                | Immedia Cause (Final disease or condition resulting in death) a.   | Notic C  | onteovas                             |                                      | isease                                  | Onset and Death                            |
|                                | Examiner   |                | Due to (or as a consequence of):   | polic du   | seale                                |                                      |   |  |
|                                | ted<br>sit   | Examine        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | . 10   |                                      |                                      |   |  |
| Ć,                             | ate be executed<br>hysician and<br>the burial-transit  | Exan           | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):   | Barr   |                                      |                                      |   |  |
| 8760,                          | te be<br>ysicial<br>e buri   | dical          | d  | 34   |                                      |                                      |   |  |
| မ                              | tificate<br>ig phys<br>as the  | ledi           |  | 77,000   | /                                    | - 10                                 | 1001                                    | 18-  |
| .O. Box                        | the death certificate be executed<br>y the attending physician and<br>ched for use as the burial-transit   | Physician/Me   |  | □Ectopic pregnancy<br>□ Other (specify)                  |                                      |                                      | 23d. Date of deli<br>Month              | very<br>Day Year                           |
| О.                             | The law requires that the de<br>ate has been signed by the a<br>bage 2 should be detached  | by             | Part II. Other significant conditions contributing to death but not resulting in the un  | inderlying cause give                                    | n in Part I.                         | 23e. Did tob                         | es 2 ☑ No 3 ☐ Pro                       | the cause of death?                        |
| COL                            | v requ   | letec          | J-1011 CV   1  |  |                                      | 24a. Was ar                          | 24h Were au                             | topsy findings available                   |
| al Re                          | The lar<br>ate has<br>page 2   | Completed      |  |  |                                      | autops<br>perforn                    | y prior to c                            | ompletion of cause of                      |
| Vit.                           | Physician: Th<br>r this certificate<br>ral director, pag   | Be             | 25. Was case referred to medical examiner?  Hospital:  | othe Othe  | r -                                  | th (Check only one                   |   |  |
| o                              | Phys<br>rthis<br>ral dia   | 2              | 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatier  27. Manuar of Death 28a. Date of Injury 28b. Time or  | III 3 DOA  | 4 M Nursing H                        | ome 5 ☐ Reside<br>28d. Describe ho   | ence 6 Other (Spec<br>w injury occurred | city)                                      |
| on                             | Attending r death. ector: After by the fune  | tion           | 1 ✓ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation  | Work   | ?<br>∕es 2 □ No                      |                                      | ,,                                      |  |
| Division or Vital Records,     | l or Atter<br>after dea<br>Director<br>I in by the   | Certification: | 3 ☐ Sulicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)  | reet, factory, office                                    |                                      | 28f. Location (St.<br>City or Town   | reet and Number or Ru<br>, State)       | ral Route Number,                          |
|                                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,   | Medical C      | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.  |  |                                      |                                      |   |  |
|                                | To the within To the comple  | Me             | 29b. Signature and title of certifier  | 29c. License   |                                      | 29                                   | 9d. Date signed (Month                  | n, Day, Year)                              |
|                                |  |                | 30. Name and address of persop who completed cause of death (Item 23a) (Type,  |  | 09.00                                | ,                                    | 3/28/08                                 | )  |
|                                |  |                | VIJAY SUARMA 16  |  | IT. ROY,                             | AL ALF.                              | BALTIMORE                               | 21217 MD                                   |
|                                | Sta  | _              | 31. Date filed (Month, Day, Year) 82. Registrar's Signature  |  |                                      |                                      |   |  |
|                                | Registr  | ar             | APR 1 0 2008 Seedies & April   |  |                                      |                                      |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Okaram State of Maryland / Department of Health and Mental Hygiene / Okaram State of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death tobson Month **Physician** essie 9 200 8 4c. County of Death 12:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** -ederick Baltimore atonsville 8. Date of Birth (Month, Day, Year) 02/11/1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 M 2 F Months 239-26-1360 97 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits artment of Health and Mental Hygiene. ortant: If flem 27 is marked other than "natural", or flems 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Catonsville 1 ☐ Yes 2 No ltimore MD Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 Avenue 416 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry toud Services Elementary/Secondary (0-12) College (1-4or 5+) COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be C ueen 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trauonce. Cousin atay 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Battimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vaughn C. Greene Fu
5154 Baltimore Natl 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due o (or as a consequence of): FAILURE ONE YEAR /Medical END STAGE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ESSEN TIAL Examiner HYPERTENSION SEVERAL signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): YEARS BESSIE M.+10 BSON Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by ONARY 1 ☐ Yes 2 No 3 Probably 4 Unknown CARDIOMYOPAT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending PhysIclan: The law 24 hours after death. Funeral Director: After this certificate has t autopsy performed?

1 Yes 2 No RHEUMATO ID 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K-Raug 00 D 18362 4-9-2008 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Ste Lio. Balto. 3455, MD. Wilkens 31. Date filed (Month, Day, Year) 0 APR 1 0 2008 62. Registrar's Signature State

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** VERNITA HARRINGTON APRIL 4, 10:15P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S FUTURECARE - PINEVIEW CLINTON 8. Date of Birth (Month, Day, Year) 4/25/1926 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 1 □ M 2 X F 81 FLORIDA 219-18-7894 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at MD PRINCE GEORGE'S TEMPLE HILLS ¹X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4408 WANDERING WAY 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSE MEDICAL permit. Pages 1 and 2 should be filed Department of Health and Mental Hygiv Important: if item 27 is marked other vany injury or other variants. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUBEN WADE JULIA EWELL 19a. Informant's Name/Relationship (Type. Print)DAUGHTER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 WANDERING WAY, TEMPLE HILLS, MD VANETTA HARRINGTON IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PIKESVILLE, MD DRUID RIDGE CEMETERY 4/12/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 10220 GUILFORD ROAD, JESSUP, MD 20794 Self: Enter the disease, of complications that cause hock, or heart failure. List only one cause on each ations that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immedi L. Cause (Final dise or condition resulting in death) Advanced Dementia, Alzheimer's Disease **Physician** /Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Stroke Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical Hypertension as attending p IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? The 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t al or Attending Patter death.

I Director: After to be 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D51520 4-7-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, MD, 1328 Southern Avenue, SE, Washington, DC 20032 31. Date filed (Month, Day, Year) gistrar's Signatu State Registrar 2008 APR 10

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

law requires that the death certificate be executed physician and the burial-transit the attending p After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

filed within 72 hours after death

al Hygiene.

th and Mental F.

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

State Registrar

Shock Trauma 31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

Center, Univ. of MD Modical Ctr. 22 5, Greene St. Balto MD 21201 32 egistrar's Signature

HAMDALLAH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AU4176435-18556

29d. Date signed (Month, Day, Year)

April, 09,2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 07 27 AM APRIL 200 SAMUEL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number JOHNS HOPKINS BAY /VIEW MEDICAL BALT IF COME A STATE OF BIRTH (Month, Day, Year) TI mone N/A 5. Social Security Number 6. Se: Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Yrs. 244-24-1564 81 MAY 4, NORTH CAROLINA 1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No MD. BALTIMORE EASTWOOD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7930 WYNBROOK RD. 21224 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTO MACHANIC AUTO 10TH 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN LIZZIE AGNES HOLLIFIELD 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY LONG/DAUGHTER 7930 WYNBROOK RD., BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 4/11/08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. (art1. Finter the dise complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SM ALL ONE MONTH Due to (or as a consequence of) ANDIAC THU DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Doe to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

23a or

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natural

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me onee.

Examiner must be notified at

Director

Funeral

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Completed

Be

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

and atten for us After within 24 hours after death To the Funeral Director:

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

| edical                          |  |  |   |   |                             |  |
|---------------------------------|--|--|---|---|-----------------------------|--|
| Physician/Me                    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Ectopic pregnancy 1 ☐ Cother (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐   |  |   | 3d. Date of delivery<br>Month Day Year  |                             |  |
| ompleted by Pr                  | Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Monknown  24a. Was an autopsy findings available prior to completion of cause of |   |                             |  |
| edical Certification: To Be Con | perform 1  |  |   |   | death?<br>1 Yes 2 No        |  |
|                                 | examiner? Hospital:  |  | Other:  | Othor   |                             |  |
|                                 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio  |  | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No   | 28d. Describe how injury  | occurred                    |  |
|                                 | 3 Suicide 6 Could not b 4 Homicide determined  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                             |  |
|                                 | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |                             |  |
| Ž                               | 29b. Signature and title of certifier  | * 1  | 29c. License number   | 29d. Date   | e signed (Month, Day, Year) |  |

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State Registrar

10+1

4940 EASTERN ALENVE BALTIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Soll MAUL M.D

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10:47 AM<sup>™</sup> 2008 March 30, Sister Maria Goretti Jones, O.S.P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 701 Gun Road
5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Apr 7, 1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔯 F 80 Yrs. Ohio Director 220-58-1400 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours after death with the Marylan al Hygiene.
I other then "natural", or Iteme 23a or 28a-1 ehow went, Ite Mudical Examinar must be nutlised at 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 701 Gun Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 ☐ Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) private homes domestic worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental H I item 27 le marked ot and Mental Evelyn Beatrice Brown E. Grafton Jones ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Gun Road Baltimore, MD 21227 Sister Ricardo/administrator 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 Dether (Specify) 21. Signatur vot Funeral Service Lie State Anatomy Board 655 W. Baltimore Street Trector Baltimore, MD 21201 m 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine certificate be executed ed by the attending physicien and detached for use as the burial-transit Nen that initiated events resulting in death) Last as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificete hes been signed by I irector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital : After this certification and funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1, Natural 5 Pending s efter death.
I Director: Aft
id in by the fun 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide ŏ within 24 hours e To the Funerel I completely filled Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ikaran\_ 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 212 BASKERN. 345T Wilkens Air. JAMBANDAY 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1.0 2008 Registrar

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth Month 1. Decedent's Name (First, Middle, Lest) Year **Physician** 2008 0345 APRIL JONES SELAH В. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🛛 F Yrs 22 MD MARCH 31, 2008 12 Director 999-99-9999 Usuel Residence of Decedent 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Be Completed by Funeral Director PRINCE GEORGE'S SUITLAND MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 20746 2303 Porter Avenue 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) None 0 None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Sheena Jones Derrell Cosby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Suitland, MD20746 2303 Porter Avenue Sheena Jones / Mother 20c. Location - City or Town, State Plece of Disposition (Name of cemetery, cremetory or other place) Date 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4-9-2008 Clinton, MD 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee 20746 SUITLAND, MD DONLAUD R. GRAY 4308 SUITLAND ROAD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA edical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Affer 5 Pending investigation 1 Natural 1 Yes 2 No efter death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the busis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifies

31. Date filed (Month, Day, Year)

APR 1 0 2008

32. Registrer's

29c. License number

29d. Date signed (Month, Day, Year)

Cheverly, Md. 20785

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:50 PM BLANCHE KEENE 2008 APRIL 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14405 WAYNESFORD DRIVE PRINCE GEORGE'S UPPER MARLBORO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Director 83 04 1924 VIRGINIA 228-28-1652 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh 1X Yes 2 No Directo DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 20011 USA 1365 SHERIDAN STREET, NW permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important; if item 27 is marked other than "naturar; or Items 23; any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Yrs. Registered Nurse Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amanda C. Gillespie unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna C. K. Shields/Daughter 14405 Waynesford Drive Upper Marlboro, MD 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-12-2008 Gate of Heaven Silver Spring, MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Marshall's Funeral Home of MD DOUBLD R. CRA 20746 4308 Suitland Road Suitland, MD 23a. Part . Enter the disease, of shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer **Physician YMedical** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical requires that the death certificate the use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 X No sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2K No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 NOther (Specify) House Hospital: 1 Tes 2 X No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; Af completely filled in by the fu

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

Vinn W

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

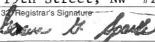
7663 DC

April 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1120 19th Street, NW #200 Washington, DC ACE LIPSON

31. Date filed (Month, Day, Year) APR 10



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Andrea Kelly-Bost   |                | I- For State                                      | St                        | ate of Ma                   | rylan                | -                        | rtment of        |                     | d Mental H                             |                           | <b>9</b>        | 000               | 8 1168  |
|---|----------------|---|---------------------------|-----------------------------|----------------------|--------------------------|------------------|---------------------|--|---------------------------|-----------------|-------------------|---|
| Physiciar   |                | Registrar<br>1. Decedent's Nam                    | e (First, Middl           | e,Lest)                     |                      |                          |                  |                     |  | 2. Date of Dea            |                 | /oar              | 3. Time of Death                                    |
| Medical Examine   | er             | ANDREA 4a. Fecility Name (                        | ELEE                      |                             |                      | BOSTON                   |                  | 1h City Town or     | Locetion of Deat                       | Month<br>March 28,        |                 | rear              | 1627 hrs  |
| ( )   |                | Doctors Co  |                           | _                           | na numi              | jer)                     |                  | Lanham              | Eccellori di Deal                      |                           |                 | George            | .,  |
| Funeral   |                | 5. Social Security N                              | Number                    | 6. Sex                      | 7.                   | Age (In yrs. la          | ast birthday)    | If Under 1 Yea      |  | _                         | rth (MM/DD/YY   |                   | thplace (State or Foreign untry)                    |
| Director  | l              | 579-96-   | 7357                      | 1 M 2                       | F                    | 44                       | Yrs              | Months Day          | rs Hours Mir                           | 04/1                      | 3/1963          |                   | MAICA   |
| any   |                | Usual Residence o<br>10a. State                   | f Decedent<br>10b. County | *                           | -                    | 10c. City,               | Town or Locat    | ion                 |  |                           | ···             |                   | 10d. Inside City Limits                             |
| . ≰   | 5              | MD  | PRINC                     | E GEORG                     | E'S                  | GRE                      | EENBELT          |                     |  | 9.5                       |                 |                   | 1 X Yes 2 No  |
| Maryla<br>28a-f   | Director       | 10e. Street and Nu                                |                           | 10.0                        |                      |                          |                  | 10f. Zip Code       |  | 1                         | 10g. Citizen of | What Cour         | ntry?   |
| vith the Maryland 23a or 28a-f show a   |                | 7505 MA   | NDAN R                    |                             |                      | lent Ever in U.          | £ 13 W/s         | 20770               | spanic Origin? ( S                     | Specify Vos or No         | USA             | ace - Ameri       | can Indian, Black,                                  |
| eath w<br>items   | Funeral        |   | ed 2 X Ma                 | arried Arm                  | ned Ford<br>Yes      |                          | If Y             | es, specify Cuba    | n, Mexican, Puert                      | o Rican, etc.)            |                 | hite, etc.        | ·   |
| after d   | by<br>F        | 3 Widowed   | 4 Div                     | orced If Yes, Gi            |                      | 2 <u>A</u> NO            | 1                | Yes 2 X No          |  |                           | Speci           |                   | ACK   |
| hours<br>natur  |                | 15. Decedent's E                                  |                           |                             | st grade<br>ege (1-4 |                          |                  |                     | tion (Give kind of<br>e. DO NOT use re |                           | 16b. Kind of    | Business/         | Industry  |
| 336<br>thin 72<br>te.<br>than   | Completed      | Elemental y/3ec                                   | oridary (0-12)            |                             | Yrs.                 |                          | Record           | s Manage            | ement Spe                              | ecialist                  | Depar           | rtmen             | t of Justice  |
|   |                | 17. Father's Name                                 | (First, Middle,           | Last)                       |                      |                          |                  | Ĭ                   | 18.Mother's Nam                        | e (First, Middle,         | Maiden Suma     | me)               |   |
| 2121<br>Auld be fi<br>Mental<br>marked<br>c event,  | Be             | unk 19a. Informant's Na                           | ame/Relations             | hip (Type, Prin             | t )                  |                          | 19b. Mailin      | Address (Stre       | Nora I<br>et and Number or             | yn Beck Rural Route Nu    |                 | own. State        | . Zip Code)   |
| MD 3  | ۱٩             | Necole  |                           |                             |                      |                          | 1.0              |                     | Road #T2                               |                           |                 |                   | 0770  |
| re, re<br>s I and<br>f Healt<br>If item   |                | 20a. Method of Dis                                |                           | 3 Remo                      | oval from            |                          |                  | ition (Name of ce   |  | Date                      | 20c. Location   | -                 | Town, State   |
| altimore,<br>mit. Pages I an<br>epartment of Hea<br>pportant: If iter   |                | 4 Donation 5                                      | Other St                  | ecify:                      | 7701 11011           | Mar                      | yland            | National            | <del>104-</del>                        | <del>12-2008</del>        | Laure           | 21, M             | Ď   |
| Balt<br>permit<br>Depart<br>Impor<br>injury   |                | 21 Signature of Eu                                | ineral Service            | XINDUD                      | RA                   | VAS                      | - 1              | Name and Addres     | s of Facility Ma<br>tland Ro           |                           | s Funer         |                   | ome of MD<br>20746                                  |
| Physician   | +              | 23a Pert I. Enter th                              | ne disease, or            | complications               |                      | /                        |                  |                     |  |                           |                 |                   | Approximate Interval Between Onset and              |
| /Medical  |                | failure. List or<br>Immediate Ceuse               | (Final disease            | 0                           | c Arrh               | ythmia                   |                  |                     |  |                           |                 |                   | Death   |
| ( ixamioi   |                | or condition resulti                              | ng in death)              | •                           |                      | onsequence o<br>iomegaly | f):              |                     |  |                           |                 |                   |   |
|   | ner            | Sequentially list co<br>if any, leading to in     | nmediate                  |                             |                      | onsequence o             | f):              |                     |  |                           |                 |                   |   |
|   | Examine        | (Disease or injury events resulting in            | that initiated            | C. Due to (o                | ras a co             | onsequence o             | f):              |                     |  |                           |                 |                   |   |
|   |                |   |                           | d                           |                      |                          |                  |                     |  |                           |                 |                   | <del> </del>  |
|   | edical         | UNPENDED  | )                         | X AMENI                     | DED It               | tem/20b,                 | c,perFH,(        | 3878 <b>,</b> 4/16/ | 08,WS                                  |                           | 100   001       |                   |   |
| Sox 68760 leath certificate be attending physicate for use as the bu  | Physician/M    | IF FEMALE:<br>23b. Was decedent<br>past 12 month: |                           | ne 1                        | Live birt            |                          | 2 Fe             | etal death 3        | Ectopic pregr                          | nancy                     | Monti           | e of deliver<br>h | y<br>Day Year                                       |
| Box 6 death cell the attended for use   | sici           | 1 Yes 2   |                           |                             | Pregnar<br>Unknow    | nt at time of de         | eath 5 O         | ther (Specify)      |  |                           | İ               |                   |   |
| the d   |                | Part II. Other sign                               | ificant condit            |                             | 1000                 |                          | esulting in the  | underlying cause    | given in Part I.                       | 23e. Did t                | tobacco use co  | ontribute to      | the cause of death?                                 |
| s, P.O. uires that the signed by d be detach  | d by           |   |                           |                             |                      |                          |                  |                     |  | . 1 Ye                    |                 |                   | bably 4 V Unknown                                   |
| Sords<br>law requii   | plete          |   |                           |                             |                      |                          |                  |                     |  | 24a. Was                  |                 | prior to          | utopsy findings available<br>completion of cause of |
| Reco<br>The lar<br>icate ha   | Completed      |   |                           |                             |                      |                          |                  |                     |  | 1 ✔ Yes                   | 2 No            | death?<br>1 ✓ Y   | es 2 No   |
| of Vital Records, ag Physician: The law require the true that been similar this certificate has been similar director, page 2 should be | Be             | 25. Was case reference examiner?                  |                           | Hospital:                   | Inc                  | patient 2                | ER/Outpatien     |                     | Other Nurs                             | k only one)<br>ing Home 5 | Residence       | 6 Othe            | r:  |
| n of Vi<br>ling Physi<br>After this   | <u>2</u>       | 1 ✓ Yes<br>27. Manner of Dea                      | 2 No                      | 28a.                        | Date of<br>(Month, D | Injury                   | 28b. Time of     |                     | ury at Work?                           |                           | how injury oc   |                   |   |
| ion<br>itendir<br>leath.<br>tor: A  | atio           | 1 V Naturel 2 Accident                            | 5 Pend                    |                             | (World), D           | yay, i bai j             |                  | 1                   | Yes 2 No                               |                           |                 |                   |   |
| Division al or Attendir rs after death. al Director: A  | Certification: | 3 Suicide   | 6 Coul                    | d not be 28e                |                      | of Injury - At h         | ome, farm, stre  | et, factory, office | building, etc.                         | 28f. Location<br>or Town, |                 | ımber or Rı       | ural Route Number, City                             |
| Divisior Hospital or Attent 24 hours after death Funeral Director:  |                | 4 Homicide  |                           | 100                         | ecify)               | of my knowled            | ge, death occu   | rred at the time, o | late and place, ar                     | due to the cau            | use(s) and mar  | ner as stat       | red.  |
| To the How within 24 h  | ledical        | (Check only one) 2                                | Medical Exa               | miner: On the t             | basis of             | examination a            | ind/or investiga | tion, in my opinio  | n, death occurred                      | at the time, date         | e and place, ar | nd due to th      | ne cause(s)   |
| F 3 F 5   | Ĭ              | 29b. Signature and                                | title of certifie         |                             | 20 0                 | 0                        |                  | 29c. Licen          |  |                           |                 |                   | inth, Day, Year)                                    |
|   |                | Cel   | rou                       | - 7t                        | T (                  | La                       |                  | 0.0                 | .M.E.                                  |                           | March 2         | y, 2008           |   |
| 5   |                | 30. Name and edd<br>Carol Allan                   |                           | who complete<br>sistant Med |                      | ,                        |                  | Street, Baltim      | nore, MD 212                           | 01                        |                 |                   |   |
| Sta   |                | 31. Date filed (Mor                               | PR 1.                     |                             | 32. P                | istrar's Signatu         | ure              |                     |  |                           |                 |                   |   |
| Registr<br>DHMH 17 Rev 1/200  | _              |   | APR 1.0                   | 2008                        | St                   | Sugar J                  | ORIGINA          |                     |  |                           |                 |                   |   |
| DI IIVITI 17 Rev 1/200  | U              |   |                           |                             |                      |                          | OKIWINA          | L.                  |  |                           |                 |                   |   |

DHMH 17 Rev 1/2001 OCME 2006

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|            |  |                  |   | State of Marylan  |                                  |  |   | =   | _  |  |
|------------|--|------------------|---|---|----------------------------------|--|---|---|--|--|
|            |  |                  | 1 - For State Ragistrar   | olato ol mai ytali  |                                  | tificate of  |   |   | 2 0 0 8                                    | 11585  |
|            | Division.  |                  | Decedent's Name (First, Middle, Last)   |   |                                  |  |   | 2. Date of Death<br>Month                     | Day Yeer                                   | 3. Time of Death                                 |
|            | Physici<br>/Medi   |                  | Ellen E. Lewis  |   |                                  |  |   | March 23                                      | , 2008                                     | 9:14 PM M  |
| ).         | Examir   | ner              | 4a. Fecility Name (If not institution, give s   |   |                                  |  | or Location of Death                      | 1   | 4c. County of Dea                          |  |
|            | Francis  |                  | 1429 Stonewood Ro   | 7. Age (In yrs.   | last birthdav)                   | ff Under 1 Year  | Baltimore If Under 24 Hrs.                | 8. Date of Birth                              | Baltim 9. Bir                              |  |
|            | Funeral<br>Director  |                  |   | M 2 <b>∑</b> F 87   | Yrs.                             | Months Days  |   | 8. Date of Birth<br>(Month, Day,<br>June 23,  | 1920 Ir                                    | thptace (State or Foreign<br>ountry)<br>eland    |
|            | yland  |                  | 10a. State 10b. County  | 10c. Cit  | y, Town or Lo                    | cation   |   |   |  | 10d. Inside City Limits                          |
|            | a-fsh  | ctor             | MD Baltimor   | e I   | 3altimo                          | re   |   |   |  | 1√Yes 2 No                                       |
|            | deeth with the Maryland<br>me 23a or 28a-f show<br>rinust be notified at   | Funeral Director | 10e. Street and Number<br>1429 Stonewood Roa  | d   |                                  | 10f. Zip Code  | 21239                                     | 10  | g. Citizen of What Co<br>USA               | ountry?  |
|            |  | nere             | 11. Marital Status  | Was Decedent Ever in U.     Armed Forces?   | S. 13. \                         | Was Decedent of I  | Hispanic Origin? (Span, Mexican, Puert    | pecify Yes or No-                             | 14. Race - Ame<br>Black, Whi               |  |
| 036        | hours after deeth with the Marylan<br>turel', or Iteme 23a or 28a-f show<br>I Examiner must be notified at   | by               | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced  | 1 Yes 27 No If Yes, Give Year or Dates:   |                                  | 1 Tes, specify Cob<br>1 ☐ Yes 2X No                          |   | o rican, etc.)                                | Specify: W                                 | -  |
| 9500-61212 | n 72 h   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade  | completed)  | 16a. Deced<br>(Give<br>life. L   | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | pation<br>during most of world)           | king  | 6b. Kind of Business                       | /Industry  |
| 7 7        | be filed within tal Hygiene. d other than event, Italia  | E O              | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                  | oyment p   |   |   | childcar                                   | e  |
|            | e filed<br>al Hygid<br>cother<br>vent, il  | BeC              | 17. Father's Name (First, Middle, Last)   |   |                                  |  | 18. Mother's Nan                          | ne (First, Middle, M                          | aiden Sumame)                              |  |
| yland      | should b<br>nd Ments<br>marked<br>umatic e   | Tof              | Joseph Patrick 0'   | Loughlin  |                                  |  | Theresa                                   | Timpson                                       |  |  |
| Mar        | tra tra  |                  | 19a. Informant's Name/Relationship (Type<br>Susan Horn/friend   | e, Print)   |                                  | -  |   | ral Route Number,<br>111ston, N               | City or Town, State, ID 21047              | Zip Code)  |
| Baltimore, | t. Pages 1 and timent of Healt tent: If item 2 fury or other   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)                 | 1 6   | lace of Dispo<br>emetery, cren   | sition (Name of<br>natory or other pla                       | ce)                                       | Date 2  | Oc. Location - City or                     | Town, State                                      |
| Balt       | Departm<br>Departm<br>Imports<br>any nlu   |                  | 21. Signature of Funeral Style License W  | ade pirector  |                                  |  | Smy Board<br>MD 2120                      |   | Baltimore                                  | Street   |
|            |  |                  | 23a. Part1. Enter the disease, or complic   | cations that caused the deat  |                                  |  |   |   | st,  | Approximate                                      |
| F          | Physician  |                  | shock, or heart faifure. List only one<br>Immediate Cause (Finaf<br>disease or condition                    | 10.   | dial                             | in force   | tion                                      |   |  | Interval Between<br>Onset and Death              |
|            | /Medical   |                  | resulting in death)   | Due to (or as a conseq  | uence of):                       | Intare   | tion<br>disease                           |   |  | W VOCERS   |
|            | Examiner   | _                | Sequentially fist conditions, b.  | Coronar   | y ar                             | tery o   | disease                                   | 2   |  | Years  |
|            | nsit   | ulne             | Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq  | uence of):                       | ٧  |   |   |  |  |
|            | be executed<br>icien and<br>burial-transit   | Examiner         | that initiated events c. resulting in death) Last   | Due to (or as a conseq  | uence of):                       |  |   | ·   |  |  |
| -          | 6 × 6  | cal              | <b>€</b> d.   |   |                                  |  |   |   |  |  |
| 9          | certifica<br>Iding ph<br>Ise as th   | Med              | IF FEMALE:  |   |                                  |  |   |   |  |  |
| Ď          | the death or<br>by the attend<br>ached for us  | Physician/Med    | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 反No 9 □ Unknown                                 | c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of default of the second of the | fdeath 3□                        | Ectopic pregnanc<br>Other (specify)                          | у   |   | 23d. Date of de<br>Month                   | fivery<br>Day Year                               |
| <b>.</b>   | ures that the de<br>signed by the a<br>id be detached f  | / Ph             | Part II. Other significant conditions cont  | inbuting to death but not res   | ulting in the ur                 | nderlying cause giv  | ven in Part I.                            | 23e. Did toba                                 | acco use contribute t                      | o the cause of death?                            |
| ecords,    | requires that<br>een signed b<br>hould be deta   | d by             | atrial fibril   | lation  |                                  |  |   | 1 ☐ Yes                                       | 2 □ No 3 (P                                | robably 4 Unknown                                |
| ဂ္ဂ        | sicten: The law requir<br>certificete has been si<br>rector, page 2 should I   | Completed        | breast can  | 05  |                                  |  |   | 24a. Was an                                   | 24b. Were a                                | utopsy findings available completion of cause of |
| Ľ,         | The It   | mo               | hypothyroid   | 1   |                                  |  |   | autopsy<br>perform<br>1 Yes 2                 | ed? death?                                 | completion of cause of                           |
|            | stan:<br>artifice<br>ctor, p   | Bec              | 25. Was cas referred to medi ≫I examiner?   | 7(1311)   |                                  |  | 26. Pface of Dea                          | th (Check only one                            | 7.10                                       | -  |
| 5          | Physician:<br>this certific<br>ral director,   | 인                | 1 ☐ Yes 2 X No  |   | ER/Outpatien                     | I 3 DOA  |   |   | ice 6 □Other (Spe                          | ecify)   |
| ב          | iding Phys<br>th.<br>After this<br>funeral dir   | lon:             | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury           | Wo   |   | 28d. Describe how                             | vinjury occurred                           |  |
| DIVISION   | Attending Physician: r death. ector: After this certific by the funeral director.  | llcat            | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of Injury - At ho  | ome farm str                     |  | ]Yes 2□No                                 | 28f Location (Stre                            | et and Number or R                         | ural Route Number                                |
| 2          | ital or its after ral Dire   | Certification:   | 4 Homicide determined   | building, etc. (Specif  | ()                               | oot, ractory, office   |   | City or Town,                                 |  | 5.4.7.65.6.7.5.7.6                               |
| :          | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | ledical          | 29a. Certifier 1 Cartifying Physic (Check only one) 2 Madical Examin  | ician: To the best of my kno<br>er: On the basis of examina<br>and manner stated.   | wledge, death<br>tion and/or inv | occurred at the ti<br>vestigation, in my                     | me, date and place<br>opinion, death occu | , and due to the car<br>rred at the time, dat | use(s) and manner a<br>e and place, and du | s stated.<br>e to the cause(s)                   |
|            | To To To the Confidence of the | Σ                | 29b. Signature and title of certifier   | 0   | 10                               | 29c. Licens  | 1 11 -                                    |   | d. Date signed (Mon                        |  |
| )          |  |                  | , The   | en  |                                  |  | 6460                                      | (   | April 3,                                   |  |
|            |  |                  | 30. Name and address of person who cor  |   | 3 (Type,                         | Print)   | an Par                                    | K N-V   | O RaH                                      | more MD  |
|            | Sta  | te               | 31. Date filed (Month, Day, Year)   | Man, MD   |                                  | voym   | un Tar                                    | - Briv  | COAI                                       | more in  |
|            | Registr  |                  | APR I U 2008  | Real M  | A Comment                        | 100  |   |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2008 Molly Frances Long 6:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Forest Hill Health & Rehab Center Forest Hill If Under 1 Year if Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F July 9, 214-14-1509 Director 1918 Tennessee Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination in without at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 109 Forest Valley Drive 21050 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arron Jackson Denney Fanny Ashe ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Boggs Road Forest Hill, Maryland 21050 Lewis Long Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/10/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** demen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2□No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 2 **A** No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

Daved

31. Date filed (Month, Pay, Year) APR I 2008

SDON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65 W. Martha 32. Registrar's Signature

29c. License number

123227

29d. Date signed (Month, Day, Year)

Apr. 110, 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jr. Lang 2008 20 P illiam /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** Baltimore Johns Hopkins Bayview Care Cente Beltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. February 4, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** XXM 2 F 220-12-4919 82 Director Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Expedient cust be restified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Oriole Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Y Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married imore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 years Crane Mechanic Stee] 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental marked William J. Lang Elizabeth Landafeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) artment of Health and ortant: If item 27 Is m Diane Marie McCue 6803 Roberts Avenue, Dundalk, Maryland 21222 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition April Date 12. 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State pernit. Page Dej artment o Important: If any injury or otte Holly Hill Memorial Middle River, MD. 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease of shock, or heart failure. Lis complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician retestate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Serves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ₽No this lon: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending 1 Natural death I Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident Certificat 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Startifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 D3576 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Bayview Cr. Baltimore 01 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 5-18 per hosp. 9878 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 28 2008 0700 SY ANTWAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center TOWSON
1 Year | If Under 24 Hrs. JONES, BOY, JASHINE, If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min. **1√** M 2 □ F none 2/28/08 Director USA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department of Health and Mental Hyglene in the trains as a crease 28a-f show Important: If Hear 27 Is marked other than "natural", or items 23a or 28a-f show any hollyo or other traumatic event, the Medical Examiner must be notified at Randallstown 1 ☐ Yes 2 ☐ No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 9803 Branchley Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Specify: African American 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) OWRY, ANTWAN (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasmine Jones Curtis Lowry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐Removal from State B9470.CI 4 □ Donation 5 □ Other (Specify) 21. Signature of Full al Service Licenses W 6924 norkion 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multicystic Renal Disease
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□No 1**∀** Yes 2 ☐ No XIX Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No XX Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1XXVIatural 5 Pending investigation n 24 hours after death.

Re Funeral Director: Affetely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide McCertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43003 2/29/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2008 32. Registrar's Signature Charles St., BALTIMORE, MD Dunsmore, Rap Kear 1 0 State A Signa

Registrar

08-02619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

008 11689 Troy J. Lyles State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0048 hrs Medical Examiner April 3, 2008 Troy J. Lyles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 3415 52nd Avenue Hvattsville If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Washington Country DC Months Days Hours Min Director 1 X M 2 F 579-06-7193 Yrs 10-10-1980 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 23a or 28a-f show notified at once. DC Washington Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4315 3rd St. S.E. #204 20032 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Never Married 2 Married Yes è Yes 2 No specify: Widowed Divorced If Yes, Give Yea Specify: Black þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' c event, the Medical Baltimore, MD 21215-0036 Furniture Mover Experience Movers 7th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cherri Lyles Carlos Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) other traumatic Cherri Lyles 4315 3rd St. S.E. Washington DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Important: If 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Washington DC Glenwood Cemetery 04-12-08 Donation 5 Other Specify: 22. Name and Address of Facility W.H. Bacon Funeral Home, 21. Signature of Funeral Service Licensee 3447 14th St. N.W. Washington DC 20010. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease ≂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical ned by the attending physician a detached for use as the burial -UNPENDED AMENDED Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate ✓ Yes 2 1 🗸 Yes the Hospital or Attending Physician: 'in 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other<sub>4</sub> examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this 1 V Yes ۵ 28a. Date of Injury (Month, Day,Year) FOUND: After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 \_ FOUND: Natural Director: Pending Yes 2 V No Apr 3, 2008 0043 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 3415 52nd Avenue, Hyattsville, MD determined (Specify) Parking Lot To the Funeral 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signatu State Registra

**ORIGINAL** 

DMMH.17.Flux.1000/d OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4, 2008 7:15 PM William Lotz, Jr. April Frank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverview Care Center Baltimore Co. Essex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 ➡ M 2 🗆 F Months Days Hours Min. Yrs. Director 16,1924 Maryland Aug. 212-20-4006 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Maxical Examination in the paying at 1 Yes 2 No Edgemere Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 U.S.A. 7240 River Drive Road Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No X Specify. Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Thompson Steel Co. Foreman permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: if item 27 is marked any Injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank W. Lotz, Sr. Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7240 River Drive Road Edgemere, Maryland 21219 Mrs. Celeste Lotz/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/9/08 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physician and for use as the burial-transit E O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 □Yes Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manney Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No ours after death. investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2008 0

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Month 8:45 A M April 6, Edward Harry Miller, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Apt. 108 Hampstead 1211 North Main St. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | March 1, 1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **X**X м 2□ F 82 Maryland 220-12-9875 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County XXYes 2 □ No Carrol1 Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21074 1211 North Main St. Apt. 108 12. Was Decedent Ever in U.S. Armed Forces? XXXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married XXMarried White 1 ☐ Yes XXNo 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

Johanna

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1211 North Main St. Apt 108 Hampstead,

Kroeger

20c. Location - City or Town, State

21074

**Physician** /Medical **Examiner** 

permit. Pages Department of Important: If it any injury or o

For State Registrar

10a. State

MD

Edward E. Miller

20a, Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Rose Marie Miller / Wife

XIX Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

VICE

APR I U

31. Date filed (Month, Day, Year)

Director

Funeral

ð

Completed

Be

2

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 2a or 28a-f show upry or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner sician and burial-trans physician Physician/Medical the attending properties for use as the by signed I \$ icate has been si Completed certificate has director this funeral tospital or Attending P thours after death.
uneral Director: After t After t Certification:

law requires that the death certificate be executed

Physiclan:

Division or Vital Records, P.O. Box 68760,

Druid Ridge Cemetery 4/9/08 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2/07-8/08 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 1 Ho 1□ Yes 26. Place of Death (Check onl one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 🗌 Yes 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Registrar

filled in by the

Medical

within 24 hours a To the Funeral I Hospital

Street Westynuster

Enemecio Ciuz Molina Santos Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-01930 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1124 hrs Enemecio Cruz Molina March 8, 2008 Santos Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Prince George's Hyattsville 1408 University Boulevard Apt. 101 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours Director 1X M 28, 1972 El Salvador 2 35 none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State any 1 X Yes 2 No s 23a or 28a-f show e notified at once. Montgomery Silver Spring permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20902 Salvador 11500 Nairn Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes Specify: White 1 X Yes 2 No specify: Salvadoran If Yes, Give Year Widowed 4 Divorced ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) Baltimore, MD 21215-0036 Construction Laborer 2nd18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ana Marta Cruz Be Lorenzo Molina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 11500 Nairn Rd. Silver Spring Maryland 20902 Olga Esperanza Zepeda (sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State La Union, El Salvador 04-13-08 Family Cemetery Donation 5 Other Specify: 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3447 14th St. N.W. Washington DC 20010. CC 36 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death /Medical a Blunt Force Injuries of the Abdomen Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED physician the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u>. Yes 2 ✓ No 3 Probably 4 Unknown þ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No No ✓ Yes 2 certificate page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Nursing Home 5 Residence 6 Other: Scene DOA Inpatient ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject assaulted Certification: FOUND: 1 Yes 2 ✔ No Natural 5 Pending filled in by the f within 24 hours after death.

To the Funeral Director: Mar 8, 2008 1123 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) Found, 1408 University Blvd Apt. 101, Hyattsville, MD determined (Specify) Multi-Family Apt 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2008 **ORIGINAL** 

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 9, 2008

and manner stated.

Assistant Medical Examiner

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

0

29b. Signature and title of certifie

Carol Allan, MD

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

|                     |   |                | Please Type or Print in Black  |   |   |  |
|---------------------|---|----------------|--|---|---|--|
|                     |   |                | - FOI  | epartment of Health and M   | ientai Hygi                               | ene<br>. N2008   1693  |
|                     |   |                | 1 - State<br>Registrar   | Certificate of Death  |   | 3.1102 0 0 0   |
| 14                  | 190 m   | -              | Decedent's Name (First, Middle, Last)  |   | <ol><li>Date of Death<br/>Month</li></ol> | Day Year   |
|                     | Physicia<br>/Medic  | _              | Mary Ann Mericle   |   | April                                     | 7 2008 9:40 P M  |
|                     | Examin  |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |   | 4c. County of Death  |
| 177                 |   | 15             | Prince George's Hospital Center  | Cheverly  |   | Prince George's  |
|                     | Funeral   | -              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth  | day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                       | 8. Date of Birth<br>(Month, Day,          | 9. Birthplace (State or Foreign<br>Year) Country)                |
| * 2                 | Director  |                | 219-12-4778 1□M 2XF 84 Y   | rs.   | Apr. 5,                                   |  |
|                     | D   |                | Usual Residence of Decedent  |   | -,  | 10d. Inside City Limits  |
|                     | nylar<br>how  |                | 10a. State 10b. County 10c. City, Town   | or Location   |   | 1 ☐ Yes 2 ☑ No   |
|                     | a-f-a   | cto            | NC Dare Kitt   | y Hawk  |   | 1 163 2 <u>A</u> 110   |
|                     | h the   | Director       | 10e. Street and Number   | 10f. Zip Code   | 10  | g. Citizen of What Country?                                      |
|                     | 72 hours after death with the Maryland<br>natural', or itema 23a or 28a-f ehow<br>Iteal Ezahrirer must be motified at   | a              | 303 Duck Road  | 27949   |   | USA  |
|                     | dea   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | <ol> <li>Was Decedent of Hispanic Origin? (Sp<br/>If Yes, specify Cuban, Mexican, Puerto</li> </ol> | ecify Yes or No-<br>Rican, etc.)          | 14. Race - American Indian,<br>Black, White, etc.                |
| 9                   | after<br>or Ita   | F              | 1 Never Married 2 Married 1 Yes 20140  | 1 ☐ Yes 2 ☒No Specity:  |   | Specify: White   |
| 8                   | ral',   | l by           | XXWidowed 4 ☐ Divorced Year or Dates:  |   |   | Specify Willied  |
| 2-0                 | 72 h  | Completed      | (Specify only highest grade completed)   | Decedent's Usual Occupation<br>Give kind of work done during most of work                           |   | 6b. Kind of Business/Industry                                    |
| 2                   | within lene.  | g              | Elementary/Secondary (0-12) College (1-4or 5+)   | life. DO NOT use retired)   |   | İ  |
| 2                   | M M M M M M M M M M M M M M M M M M M   | ő              | 12th 5+  | Homemaker   |   | Own Home   |
| b                   | be filed vital Hygie<br>of other i  | Be (           | 17. Father's Name (First, Middle, Last)  | 18. Mother's Nam  | e (First, Middle, M                       | faiden Sumame)   |
| Maryland 21215-0036 | Aenit<br>Aenit<br>rked  | To             | Lee Moffett  | Alma  | Moore                                     |  |
| ary                 | 2 should be and Menial Is marked o  | . 4            | 19a. Informant's Name/Relationship (Type, Print) 19b.  | Mailing Address (Street and Number or Run   | al Route Number,                          | City or Town, State, Zip Code)                                   |
| Σ                   | ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiens. If Item 27 is marked other then "natural", or Itema 23a or 28a-1 show or other traumatic event, the Madical Examinar mant has notified at |                |  | Bryants Nursery Rd  |   |  |
| Baltimore,          | of He   |                | cemeter  | Disposition (Name of crematory or other place)  | Date 2                                    | 20c. Location - City or Town, State                              |
| E                   | permit. Pages<br>Department of i<br>Important: If It<br>eny injury or o   |                | 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West A   | rundel Crem. 4/10/  | /2008                                     | denton, MD   |
| Ē                   | orta  |                | 21. Signature of Funeral Service Licensee  |   |   | Funeral Home, P.A.   |
| ñ                   | Depa<br>Impo<br>eny ii  |                | DM 100 Frank MO1103  | 313 Talbott Avenue  |   | 7,000  |
|                     |   |                | 23a. Part 1 Enjer the disease, or complications that caused the death. Do no shock, of heart failure. List only one cause on each line.  | ot enter the mode of dying, such as cardiac   | or respiratory arre                       | st, Approximate<br>Interval Between                              |
| 1                   | 1 2 8   |                |  |   |   |  |
|                     | Physician /Medical  |                | disease or condition resulting in death)   | TREASU PANLUE   | 2   |  |
| 4                   | Examiner  |                | 40 750 1136-0  | HEART FAILUR<br>Enotit CANDIOVA   | verland                                   | Disease  |
|                     |   | e              | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or   | f):   | Julian 1                                  |  |
| V                   | ted<br>nslt   | ul u           | Cause. Enter Underlying Cause (Disease or injury   |   |   |  |
| /                   | be executed<br>ician and<br>burial-transli  | Examin         | that initiated events c. Due to (or as a consequence of the consequenc | f):   |   |  |
| 760,                | e be executed<br>ysician and<br>e burial-transit  | alE            |  |   |   |  |
| 687                 | The faw requires that the death certificate itehas been signed by the attending physioage 2 should be detached for use as the ina   |                | d  |   |   |  |
|                     | ding  | Physician/Medi | IF FEMALE: 23c. If yes, outcome of pregnancy   |   |   | 23d. Date of delivery  |
| Вох                 | atten   | lan            | in the past 12 months?   | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |   | Month Day Year   |
| o.                  | the d   | yslc           | 1 Yes 2 XNo 9 Unknown  | 0 (0),  |   |  |
| σ.                  | res that the de<br>signed by the a<br>be detached f   |                | Part II. Other significant conditions contributing to death but not resulting in   | the underlying cause given in Part I.   | 23e. Did tob                              | acco use contribute to the cause of death?                       |
| Vital Records,      | sign<br>a pe  | by             | Unitral Value Replacement de   | 12 4n 110 SA  | 1 □ Ye                                    | s 2 No 3 Probably 4 Unknown                                      |
| Ö                   | w requir<br>been si<br>should   | Completed      |  | 4 10 /4/1201  | 040 146000                                | 24h Wasa sutangu findings available                              |
| ec                  | has b   | du             | endocarditis   |   | 24a. Was as autops perform                | y prior to completion of cause of                                |
| =                   |   | So             | Respiratory Pailore Vents  | lator depender  | 1 Yes 2                                   |  |
| /ita                | Physician: Th<br>r this certificate<br>ral director, pag  | Be             | 25. Was case referred to medical examiner?   | T - :   | th Check only on                          | θ)   |
| of/                 | Physic<br>this c  | 2              | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ npatient 2 ☐ ER/Out   |   |   | nce 6 Other (Specify)  |
|                     | ding P  | ü              | 27. Manner of Death 1 ☐Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Ir  | jury Work?  | 28d. Describe no                          | w injury occurred  |
| 9                   | Attending or death.   | cat            | 2 Accident investigation 3 Suicide 6 Could not be  | M 1 Yes 2 No  |   |  |
| Division            | or Attend<br>after death<br>Director:   | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)   | m, street, factory, office  | 28f. Location (St.<br>City or Town        | reet and Number or Rural Route Number,<br>n, State)              |
|                     | ital or ral D   |                |  |   |   |  |
|                     | To the Hospital or Att<br>within 24 hours after d<br>To the Funeral Direct<br>completely filled in by   | edical         | 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge (Check only 2 ☐ Medical Examiner: On the basis of examination and   |   |   |  |
|                     | the the the the the the the the the the   | Med            | one) and manner stated.  | 29c License number  |   | 9d Date signed (Month Day Year)                                  |
|                     | Voit<br>Cor   | -              | 29b. Signature and title of certifier  | Los cicarisa riumbar  | , ,                                       | 1 A 2 7 C -  |
|                     |   |                | Intelled with  | × 101870  | / /s                                      | HICK & 2008  |
|                     | 12  |                | 30. Name and address of person who completed cause of death (Item 23a) (   | Type, Print)  | 4 7                                       | 5. " 11 . A. A. A. A. 200  |
|                     | 10  |                | Lan H. DEVOSE MIS LO   | 3 Charloppond Ka  | reflet                                    | N 1 ( 4 10M) 20191   |
|                     | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year) APR 1 2008   | Aparle .  |   | 9d. Date signed (Month, Day, Year)  FIRE 2008  TO ILLE MA) 20781 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2008 Year Physician APRIL 5, SAMUEL C. MADISON 5:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 2912 MCCOMAS AVENUE KENSINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day 1922) Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Sex 11 M 2□ F Days Hours Min. SOUTH CAROLINA 250-18-1505 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 X Yes 2 □ No MONTGOMERY Director KENSINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2912 MCCOMAS AVENUE 22895 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry
UNITED HOUSE OF
PRAYER FOR ALL
PEOPLE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BISHOP/MINISTER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL MADISON ROSA LEE MADISON ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELORES MADISON / WIFE 2912 MCCOMAS AVENUE, KENSINGTON, MD 22895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ENTOMBMENT LINCOLN CEMETERY 4/14/2008 SUITLAND, MD of Funeral Service Licens 22. Name and Address of Facility HOWELL, FUNERAL, HOME 21. Signature 10220 GUILFORD ROAD, JESSUP, MD 20794 Ten 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on experience. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10+01V /Medical Due to (or as a consequence of): Examiner anches Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day ģ Month Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached for 9☐Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 1□ Yes 2 No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To. 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA ō After this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division or Attending 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02 JOX 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:05 AM William Ρ. McKenna April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 911 W. Lake Ave. Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 213-50-1702 73 1934 Massachusetts June 8. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at N/A Baltimore City 1 X Yes 2 □ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 911 W. Lake Avenue 21210 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Priest Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McKenna Catherine Byrne Patrick 2 19a. Informant's Name/Relationship (Type. Print) Fellow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other trau 1130 N. Calvert Street Baltimore, Maryland 21202 St. Joseph Society Sacred Heart- Priest 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/12/08 Baltimore, MD New Cathedral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 and 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the prode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 1 within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

State

Registrar

600

29b. Signature and title of

31. Date filed (Month, Day, Year)
APR 1 0 2008



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 8878 4-10-08 vt.
State of Maryland Department of Health and Mental Hygiene

|                            |  |                | 1 - State Registrar Certificate of Death   |                                       | Reg. No. 211696  |
|----------------------------|--|----------------|--|---------------------------------------|--|
|                            | Physicia   | an             | 1. Decedent's Name (First, Middle, Last)  Rose Oprea   | 2. Date of De<br>Month                | Day Year   |
| Wes                        | /Medic   |                | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea   | <u>  April</u>                        | 7, 2008 8:20 A M                                       |
| 7                          | Examin   | er             | 5407 A Old Frederick Road Catonsville  |                                       | Baltimore  |
|                            | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs  |                                       | th 9. Birthplace (State or Foreign                     |
| -∳4.                       | Director   |                | 214-22-2523 99 Yrs. 99   | Aug. 6                                | ,1908 Maryland   |
|                            | and<br>w   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                                       | 10d. Inside City Limits                                |
|                            | Maryl<br>f sho   | ō              | Maryland Baltimore Catonsville   |                                       | 1 ☐ Yes 2 🔼 No   |
|                            | r 28a  | Directo        | 10e. Street end Number 10f. Zip Code   |                                       | 10g. Citizen of What Country?                          |
|                            | th with  | alD            | 5407 A Old Frederick Road 21229  |                                       | USA  |
|                            | r dea<br>tems<br>er mi   | Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  | Specify Yes or No<br>rto Rican, etc.) | 14. Race - American Indian,<br>Black, White, etc.      |
| 36                         | s afte   | by Fi          | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Year or Dates:   |                                       | Specify: White   |
| 21215-0036                 | 72 hours after death with the Maryland<br>'natural', or Items 23a or 28a-f show<br>dical Examiner must be notified at  | ted t          | 15. Decedent's Education 16a. Decedent's Usual Occupation  |                                       | 16b. Kind of Business/Industry                         |
| 215                        | thin 7;<br>e.<br>an "n<br>Medi   | Completed      | (Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)   | orking                                |  |
| 2                          | ed wii   | S              | 4 Clerk  |                                       | Retail   |
| Maryland                   | be fill he start he s | To Be          |  | ,                                     | , Maiden Surname)                                      |
| 7                          | thould<br>ad Me<br>mark<br>matic   | ۴              | 19a. Informant's Name/Relationship ( <i>Type. Print</i> )  19b. Mailing Address ( <i>Street and Number or Relationship</i> )   | Grace G                               |  |
| Ma                         | nd 2 sulth ar  |                | Salvatore Brocato - Nephew 5407 A Old Frederick  |                                       |  |
| re,                        | of Hee   |                | 20a. Method of Disposition 20b. Place of Disposition (Name of complete comp | Date                                  | 20c. Location - City or Town, State                    |
| imo                        | Page<br>nent c   |                | 4 Donation 5 Other (Specify) Metro Crematory 4/9   | /2008                                 | Catonsville, Maryland                                  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   |                | 21. Signature of Funeral Service Licensee  | erling /                              | chton Schunh Witzko                                    |
| Ш                          | 205 20   |                | Mo/490 1630 Edmondson Ave  | nue; Cat                              | le, Inc.   |
|                            |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.   | ac or respiratory a                   | Interval Between Onset and Death                       |
|                            | Physician /Medical   |                | Immediate Cause (Final disease or condition resulting in death)  a.   Acteno Carunona disease or condition resulting in death)   |                                       | nonths   |
|                            | Examiner   |                | Due to (or as a consequence of);   |                                       |  |
|                            |  | ner            | Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):   |                                       |  |
| V                          | ocuted<br>nd<br>transit  | Examine        | Cause, Enter Underlying Cause (Disease or injury that initiated events  c  |                                       |  |
| 90,                        | oe exe<br>cian a<br>urial∹   |                | resulting in death) Last Due to (or as a consequence of):  |                                       |  |
| 68760,                     | rtificate be executed<br>ng physician and<br>as the burial-transit   | Medical        | d  | <u>_</u>                              |  |
| Box (                      |  |                | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy  |                                       | 23d. Date of delivery                                  |
| ŏ.                         | death ce<br>e attendii<br>d for use  | Physician/I    | in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Yes 2 □ No □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ □ Other (specify) □ Other (spe |                                       | Month Day Year   |
| P.0.                       | at the<br>by the<br>tache  | hys            | 9 □Unknown 9□Unknown   |                                       |  |
| s,                         | igne<br>igne<br>be o   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                       | tobacco use contribute to the cause of death?          |
| ord                        | requil   | ted            |  | 1                                     | Yes 2. No 3 Probably 4 Unknown                         |
| 3ec                        | has b  | Completed      |  | 24a. Was<br>auto                      |  |
| a                          | n: The ficate har, page  |                | OF Was appearatored to medical   | 1□ Yes                                | 2- No 1 Yes 2 No                                       |
| <u>S</u>                   | Physician:<br>r this certific<br>ral director,   | o Be           | examiner'  | eath (Check only o                    | one) idence 6 🗆 Other (Specify)                        |
| 0                          | g Phy<br>ter this<br>neral c   | n: To          | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at  | 28d. Describe                         | how injury occurred                                    |
| SIO                        | Attending<br>r dea h.<br>ector: After<br>by the funer  | atio           | 2 Accident investigation M 1 Yes 2 No  |                                       |  |
| Division or Vital Records, | or Attending Physician: Thifer death.  Director: After this certificate in by the funeral director, pag  | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (<br>City or To         | Street and Number or Rural Route Number,<br>wn, State) |
|                            | Hospital of hours of Funeral C   |                | 29a. Certifier 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.   | and due to the                        | cause(s) and manner as stated                          |
|                            | e Hos<br>24 hc<br>e Fun<br>letely  | Medical        | (Check only 2 Medical Examinar: On the bacic of examination and/or investigation in my eninion death on  | ourred at the time                    | data and place, and due to the aguacia)                |
|                            | To the Hospital or Attent<br>within 24 hours "fler death<br>To the Funeral Director:<br>completely filled in by the  | Me             | 29b. Signature and title of certifier 29c. License number  |                                       | 29d. Date signed (Month, Day, Year)                    |
|                            |  |                | Darles Reclaim 1 D24781  |                                       | april 12 200 8   |
|                            | 10   |                | 29b. Signature and title of certifier    Chalco Cypland in   29c. License number     29c. License numb | 1 . 1 1                               | MIE BALTO  |
|                            |  |                | CHARLES R. GRAHAM, MD 1001 Pine F  31. Date filed (Month, Day, Year)  32 Aegistrar's Signature   | teight                                | 5 HVC. MD 21229  |
| 3                          | Sta<br>Registr   | _              | APR 1 0 2008 April 1 South   |                                       |  |

|                            |   | ٠                | for<br>State<br>Registrar  | State of Maryland   |                              | tificate of   |   | Re                                    | eg. No.2 0 0 8                                  | 11697  |
|----------------------------|---|------------------|--|---|------------------------------|---|---|---------------------------------------|---|--|
| П                          | Physici   | an               | 1. Decedent's Name (First, Middle, Las   | t)  |                              |   |   | Date of Deat     Month                | Day Year  | 3. Time of Death                                 |
|                            | /Medio  |                  | Eileen M. Peery  4a. Facility Name (If not institution, give   | street and number)  |                              | 4h City Town o  | r Location of Death                                     | April                                 | 4 2008<br>4c. County of Deat                    | 1:30 PM <sup>M</sup>                             |
| 7                          | Examir  | er               | Genesis Health   | · ·   | ines                         |   | ston  |                                       | Talb  |  |
| 9                          | Funeral<br>Director   |                  | 5. Social Security Number 6. Social Security Number 1. Social Security |   |                              |   | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Nov 16, | Year) 9. Birt                                   | hplace (State or Foreign<br>untry)<br>cyland     |
|                            | land<br>w<br>t  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,  | Town or Lo                   | cation  |   |                                       |   | 10d. Inside City Limits                          |
|                            | the Mary<br>28a-f sho<br>otified a  | ector            | MD Talbot  10e. Street and Number  | E .   | aston                        | 10f Zin Code  |   | 11                                    | 0g. Citizen of What Co                          | 1 □ Yes 🌂 □ No                                   |
|                            | ath with t  | Funeral Director | 12 Willis Avenue   |   | - y-                         | 10f. Zip Code 216   |   |                                       | USA   |  |
| 21215-0036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | ρ                | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:             | '                            | Vas Decedent of H<br>f Yes, specify Cub:<br>I □ Yes 2☑ No | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)      | 14. Race - Ame<br>Black, Whit<br>Specify: Wh    | e, etc.  |
| 5                          | "natu<br>"natu<br>edical  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra   | ucation<br>de completed)  | 16a. Deced                   | lent's Usual Occup<br>kind of work done                   | ation<br>during most of work<br>d)                      | <sub>ing</sub> unk                    | 16b. Kind of Business/                          | Industry   |
| 12                         | within<br>ene.<br>than<br>he Me   | дшс              | Elementary/Secondary (0-12)  | College (1-4or 5+)  | iire. L                      | OO NOT use retired  | 2)  |                                       | office  |  |
| <u>d</u> 2                 | i filed<br>I Hygi<br>other<br>ent, ti   | Be Co            | 17. Father's Name (First, Middle, Last)  |   |                              |   | 18. Mother's Name                                       | e (First, Middle, N                   |   |  |
| ılan                       | uld be<br>Menta<br>rrked<br>tic ev  | To B             | Walter Norris Gi   | 11  |                              |   | Carolin   | e Cather                              | ine Kammke                                      |  |
| , Maryland                 | and 2 sho<br>saith and N<br>27 is ma<br>er trauma   |                  | 19a. Informant's Name/Relationship (7 Claudia Messick/   | " '   |                              |   | and Number or Run<br>Oak Road 1                         |                                       | , City or Town, State, 2<br>MD 21601            | Zip Code)  |
| Baltimore,                 | Pages 1 and of He nut: If Item  |                  | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other (Specify  | Removal from State cei  | ce of Dispo<br>metery, crer  | sition (Name of<br>natory or other plac                   |   | Date                                  | 20c. Location - City or                         | Town, State                                      |
| Balti                      | permit. Departm Importa any inju  |                  | 21. Sign fund Funeral Strain Licen   | Winderor  |                              |   | ss of Facility<br>Omy Board<br>MD 2120                  |                                       | Baltimore                                       | Street   |
|                            |   |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only   | plications that caused the death.   |                              |   |   |                                       | est,  | Approximate<br>Interval Between                  |
|                            | Physician /Medical  |                  | Immediate Cause (Final disease or condition resulting in death)  | a Alzheim   |                              | lementie  |   |                                       |   | Onset and Death  4CAS                            |
|                            | Examiner  |                  |  | Due to ras a conseque   | ence or):                    |   |   |                                       |   |  |
| - 2                        | uted<br>Insit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Due to (or as a conseque  | ence of):                    |   |   |                                       |   |  |
| 68760,                     | rificate be executed<br>ig physician and<br>as the burial-transit   |                  | resulting in death) Last   | Due to (or as a conseque  | ence of):                    | ·   |   |                                       |   | -  |
|                            | tificate<br>g phys<br>as the  | ledical          |  | .d.   |                              |   |   |                                       |   |  |
| P.O. Box                   | The law requires that the death cer<br>ate has been signed by the attendin<br>bage 2 should be detached for use   | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregnan<br>1 □Live birth 2 □ Fetal of<br>4 □ Pregnant at time of dea<br>9 □ Unknown | leath 3□                     | Ectopic pregnancy Other (specify)                         | /   |                                       | 23d. Date of de<br>Month                        | ivery<br>Day Year                                |
|                            | luires that in signed by lid be deta  | d by Ph          | Part II. Other significant conditions of Occop Hal News  |   |                              |   |   | 23e. Did tob                          | pacco use contribute to                         | the cause of death?                              |
| Division or Vital Records, | 2 88 2  | Completed by     |  |   |                              |   |   | 24a. Was al<br>autops<br>perforr      | y prior to                                      | utopsy findings available completion of cause of |
| a                          | iclan: Th<br>certificate<br>ector, pag  |                  | 25. Was case referred to medical   |   |                              |   | 00.01 (0.00   | 1□ Yes                                | No 1 ☐ Yes                                      | 2□ No  |
| ₹                          | /sicla<br>s certi   | o Be             | examiner?  | Hospital: 1 ☐ Inpatient 2 ☐ E   | R/Outpatien                  | t 3 DOA Oth   | er: 4 Nursing Ha  |                                       | <i>e)</i><br>ence 6 □Other <i>(Spe</i>          | oif d  |
| 0                          | g Physicar this leral di  | n: To            | 27. Manner of Death  |   | 28b. Time of                 |   |   |                                       | ow injury occurred                              | cny)   |
| jo                         | Attending Physician: or death. ector: After this certification by the funeral director, I   | atio             | 1 Natural 5 Pending 2 Accident investigation   |   | Injury                       |   | Yes 2 □ No  |                                       |   |  |
| Divis                      | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of injury - At hom building, etc. (Specify)  | ie, farm, str                | eet, factory, office                                      |   | 28f. Location (St<br>City or Town     | reet and Number or Ri<br>n, State)              | ural Route Number,                               |
|                            | To the Hospital or within 24 hours affer To the Funeral Dir completely filled in  | Medical          | 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam   | ysician: To the best of my know<br>niner: On the basis of examination<br>and manner stated.                 | ledge, deatl<br>on and/or in | n occurred at the til<br>vestigation, in my o             | me, date and place,<br>opinion, death occur             | and due to the cared at the time, d   | ause(s) and manner as<br>late and place, and du | s stated.<br>e to the cause(s)                   |
| )                          | To the within   | Ž                | 29b. Signature and title of certifier  | 5   |                              | 29c. Licens   | e number<br>2593)                                       | 3                                     | 9d. Date signed (Mont                           | h, Day, Year)<br>08                              |
|                            |   |                  | 30. Name and address of person who of MICHALL CROWN  | EY MD GIO   | DUT                          | Print)<br>CHMANS  | LANK  | EAS                                   | TON, MD   | 21601  |
|                            | Sta   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signatu   |                              |   |   |                                       | ,   |  |
| DH                         | Registr<br>MH 17 Rev 1/2  |                  | APR 1 0 2008   | Marine H.   | Sour                         | w   |   |                                       |   |  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADD150N 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-13-1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Months Hours Days Viřginia 231-16-4263 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 21075 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Metro College (1-4or 5+) Bus Driver Transit Authority 18. Mother's Name (First, Middle, Maiden Surname)

10a. State Director Maryland 10e. Street and Number 8029 St. Jean Way by Funeral 1 ☐ Never Married 2 ★ Married 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) James Painter Flossie Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Painter (Wife) 8029 St. Jean Way Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place)
MeadOwridge Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-11-2008 Elkridge, Maryland Memorial Park 21. Signature of Funeral Service licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 MOIDS 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

nding physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

Physician

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a ~~^^ any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin any injury or other traumatic event, the Martin and Europe events and injury or other traumatic events.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| 9(001.                                 | 7250 Washington Biva: Bikinge, IB 21                                   | 075                                   |
|--|--|---------------------------------------|
| omplications that caused the death. Do | to not enter the mode of dying, such as cardiac or respiratory arrest, | Approxima<br>Interval Be<br>Onset and |
| a. Hult                                | myourdist latere Tion  |                                       |
| Due to (or as a consequence            | nel Aatic Anly Su  |                                       |
| b. Due to (or as a consequence         |  |                                       |
| · Cardion                              | yopatting  |                                       |
| Due to (or as a consequence            | pe of):  |                                       |
| d                                      |  |                                       |
|  |  |                                       |

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No 3 Probably 4 Onknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 10 27. Manner of Death 1/ Natural 5 ☐ Pending investigation

Hospital: 1 Impatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

> 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

determined

State Registrar

after death

within 24 hours a

DL, Suite 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25,28a-f per me,8878,04/10/08ahb ar Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** HARO 17,2008 Drugry 11, ac-TNIT /Medical 4a. Facility Name (If not institution, give street and number) wn, or Location of Death Examiner Vacules ity Number NIA Genera a If Under 24 Hrs and 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year 6. Sex **Funeral** Min. Months Days 1 □ M 2 🗖 F Hours Director AND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo MARVLAND 10e. Street and Number 10f. Zip Code 10g. Cirizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married Daltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 Divorced Yorker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IPPODROME THEATER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SSES ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural R∮ute Number, City or Town, State, Zip Code) SHIRLEY JOR. E 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address . FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eterminec /Medical Due to (or as a consequence of) **Examiner** lethodore, Benzodiozepino Overlune aine Faquentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last entially list conditions Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): STRUMPATION APPROVED BY MEDICAL EXAMINER Box 68760. attending physician Physician/Medical the as for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a Id be detached f 1 Yes 2 □ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 **X** No 2□ No 1∐ Yes Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27(No Hospital: ပ 1 X Yes 1 X Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 □ Natural 5 Pending investigation 1 ☐ Yes 🚁 No 02/13/08 Unknown<sup>M</sup> Unknown 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Baltimore City, Maryland 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Malate Day, Year)

DIC

2008

32 Registrar's Signature

|                     |  |                  | For State  | State o                    | f Marylan                               | •                                       | artment<br>rtificate                    |                         |                   | and M           |                                 |               | 000         | 0                      | 1170                        | . ) |
|---------------------|--|------------------|--|----------------------------|---|---|---|-------------------------|-------------------|-----------------|---------------------------------|---------------|-------------|------------------------|-----------------------------|-----|
|                     | * A1   |                  | Registrar  1. Decedent's Name (First, Middle, La   | st)                        |   | 061                                     | inicate                                 | J OI L                  | calli             |                 | 2. Date of De                   | Reg. No.      |             | 3                      | . Time of Death             | 1   |
| 364                 | Physicia   |                  | Lucile Burgess R   |                            |   |   |   |                         |                   |                 | March                           | Day<br>28     | 200         | ear                    | 6:15PM                      |     |
| 245<br>245<br>245   | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, giv   |                            | mber)                                   |   | 4b. City,                               | Town, or I              | Location of       | of Death        |                                 |               | ounty of E  |                        |                             |     |
| ,                   | Examini  | C1               | Riderwood Villa  | ge                         | ,                                       |   | Silve                                   |                         |                   |                 |                                 | Mo            | ontgo       | omery                  |                             |     |
|                     | Funeral  |                  | 5. Social Security Number 6. S   | ex                         | 7. Age (In yrs.                         | last birthday)                          | If Under<br>Months                      | 1 Year Days             | If Under          | 24 Hrs.<br>Min. | 8. Date of Birl<br>(Month, Da   | h<br>v. Year) | 9.          | Birthplace<br>Country) | (State or Foreign           | }   |
| и                   | Director   |                  | 579-40-9665  | □M 2 <b>X</b> )F           | 81                                      | Yrs.                                    | WOULIS                                  | Days                    | riouis            | JAIII.          | Aug 13                          | , 192         | .7 Wa       |                        | gton DC                     |     |
|                     | pu v   |                  | Usual Residence of Decedent  10a. State 10b. County  | -                          | 10c Cit                                 | ty, Town or Lo                          | cation                                  |                         |                   |                 |                                 |               |             | 10d                    | Inside City Limits          |     |
|                     | laryle<br>shor   | 5                |  |                            |   |   |   |                         |                   |                 |                                 |               |             |                        | 1 □Yes 2 No                 |     |
|                     | the M  | ect              | MD Montgome  10e. Street and Number  | ГУ                         |   | 2110                                    | er Sp                                   |                         |                   |                 |                                 | 10q. Citize   | n of Wha    |                        |                             | _   |
|                     | with<br>la or  |                  | 3122 Gracefield R  | oad #50                    | 16                                      |   |   | 2090                    | 4                 |                 |                                 |               | USA         | it country.            |                             |     |
|                     | leath<br>ns 23<br>musi   | Funeral Director | 11. Marital Status   | 12. Was Dec                | edent Ever in U                         | .S. 13. \                               |   |                         |                   | gin? (Spe       | ecify Yes or No<br>Rican, etc.) |               |             | American I             | ndian,                      | _   |
|                     | fler c<br>r iter   | Ē                | 1 Never Married 2 Married  | Armed For 1 ☐ Yes          | 2 <b>1</b> ∑ No                         |   |   |                         |                   | i, Puerto       | Rican, etc.)                    | i             |             | White, etc.            |                             |     |
| g                   | nurs a   | þ                | 3 Widowed 4 Divorced   | If Yes, Gi<br>Year or D    | ve<br>)ates:                            |   | 1 □ Yes 2                               | 5 <b>K</b> ↑ No         | Specify:          |                 |                                 | 5             | pecify:     | white                  |                             |     |
| 2                   | filed within 72 hours after death with the Maryland<br>Hyglene.<br>ther than "natural", or items 23a or 28a-f show<br>other, the Medical Examiner must be notified at  | Completed        | 15. Decedent's E<br>(Specify only highest gra  | ducation<br>ade completed) |   | 16a. Deced                              | dent's Usua<br>kind of wor<br>DO NOT us | al Occupa<br>rk done di | tion<br>uring mos | t of worki      | ng                              | 16b. Kind     | of Busin    | ess/Indust             | ry                          |     |
| 2                   | rithin<br>ne.<br>" nar "   | ğ                | Elementary/Secondary (0-12)  | College (                  | 1-4or 5+)                               |   |   |                         |                   |                 |                                 |               |             |                        |                             |     |
| 2                   | filed w<br>Hygier<br>Sther the   | ਨ                | 12 17. Father's Name ( <i>First, Middle, Last</i>  | 2                          |   | inte                                    | rior                                    |                         | _                 | r's Nama        | (First, Middle,                 |               | cora        | ting                   |                             | _   |
| Maryland 21215-0036 | be d all all all all all all all all all a   | Be               | Warren Baker Bur   |                            |   |   |   |                         |                   |                 | Dona1d                          |               | umame       |                        |                             |     |
| Ž                   | 12 should be filed within 72 hours after death with the Marylar h and Mental Hyglene. Its marked other than "natural", or items 23a or 28a-f show the marked other than "natural", or items 25a or 28a-f show are marked other than "hedical Examiner must be notified at traumatic event, the Medical Examiner. | 은                | 19a. Informant's Name/Relationship   |                            |   | 19b. Mailir                             | na Address                              | (Street a               |                   |                 | al Route Numb                   |               | Town. Sta   | ate. Zip Co            | de)                         | _   |
| ĕ                   | and 2 sealth ar n 27 Is  |                  | William E. Hartur  |                            | se                                      |   | -                                       |                         |                   |                 | 506 Si                          |               |             |                        |                             | ,   |
| altimore,           | L L L  |                  | 20a. Method of Disposition   |                            | 20b. F                                  | Place of Dispo<br>cemetery, crer        | sition (Nam                             | ne of                   |                   | Ε               | Date                            | 20c. Loca     | ation - Cit | y or Town,             | State                       | _   |
| 9                   | Pages<br>ent of<br>ht: If I  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐<br>4 🕅 Donation 5 ☐ Other (Specia   | Removal from               | State                                   | cemetery, crei                          | natory or o                             | uiei piace              | 7                 |                 |                                 |               |             |                        |                             |     |
| Ħ                   | permit. Pages Department of I Important: If Ite any Injury or of   |                  | 21. Signature of Euneral Service Lice ROn 310 S  |                            | lirector                                | r 524                                   | Name an                                 | d Addres                | s of Facilit      | Xard            | 655 W.                          | Ra1t          | imor        | e Sti                  | reet                        | _   |
| m                   | an ber   |                  | Juna 1   |                            |   |   | ltimo                                   |                         |                   |                 |                                 | Dul           | - 1110 1    |                        |                             |     |
|                     | 77   |                  | 23a. Part I. Enter the disease, or con<br>shock, or heart failure. List only   | plications that            | caused the deat                         |   |   |                         |                   |                 |                                 | rrest,        |             | Int                    | proximate<br>terval Between |     |
| ,                   | Physician  |                  | Immediate Cause (Final disease or condition  | E                          |   | tage                                    | d                                       | em.                     | enti              | a               |                                 |               |             | Or                     | nset and Death              |     |
| 1                   | /Medical   |                  | resulting in death)  | Due to                     | (or as a conseq                         |   | )                                       | 11                      | enti<br>ase       |                 |                                 |               |             |                        |                             | _   |
| i.                  | Examiner   |                  | Sequentially list conditions,  | bP                         |   | 1500                                    | <u>s</u> C                              | use                     | <u>a se</u>       | 2               |                                 |               |             |                        |                             |     |
|                     | sit sit  | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to                     | (or as a conseq                         | hym                                     | idic                                    | ha                      |                   |                 | ,                               |               |             |                        |                             |     |
|                     | secute<br>and<br>trans   | хагл             | that initiated events resulting in death) Last   | C. Due to                  | (ords a conseq                          |   | 1943                                    | ,,,                     | _                 |                 |                                 |               |             |                        |                             |     |
| 8760,               | be ey  |                  |  | 240 10                     | (0.000 0.0000                           | , |   |                         |                   |                 |                                 |               |             |                        |                             |     |
| 387                 | ficate be executed<br>physician and<br>is the burial-transit   | dical            |  | ⊆d                         |   |   |   |                         |                   |                 |                                 |               |             |                        |                             | _   |
| ×                   | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | /Me              | IF FEMALE:<br>23b. Was decedent pregnant   |                            | tcome pf pregna                         |   |   |                         |                   |                 |                                 | 23            | 3d. Date o  | of delivery            |                             |     |
| . Box               | death<br>e atte  | Physician/M      | in the past 12 months?   | 4☐Preg                     | birth 2 □ Feta<br>nant at time of o     |   | ∃Ectopic pr<br>∃Other (sp               |                         |                   |                 |                                 |               | Month       | Da                     | y Year                      |     |
| O.                  | t the o  | hys              | 9 Unknown  | 9LJUnkr                    | nown                                    |   |   |                         |                   |                 |                                 |               |             |                        |                             | _   |
| ď,                  | w requires that the de<br>been signed by the<br>should be detached   | by P             | Part II. Other significant conditions  | contributing to c          | leath but not res                       | sulting in the u                        | nderlying ca                            | ause give               | n in Part I       |                 | 23e. Did t                      | obacco us     | e contribu  | ite to the c           | ause of death?              |     |
| ğ                   | equire<br>en sig<br>ould b   | ed t             |  |                            |   |   |   |                         |                   |                 | 1 🗆                             | Yes 2         | No 3[       | Probabl                | y 4 ∏Unknown                | 1   |
| Records,            | has be   | Completed        |  |                            |   |   |   |                         |                   |                 | 24a. Was                        |               | 24b. Wer    | re autopsy             | findings available          | è   |
|                     | The ate har page   | E O              |  |                            |   |   |   |                         |                   |                 | perfo<br>1∐ Yes                 | rmed?<br>2☐No | dea         | th?                    | ≥No                         |     |
| Vital               | siclan: The certificate har rector, page   | Be               | 25. Was case referred to medical examiner?   |                            |   |   |   |                         |                   | of Death        | (Check only                     | ne)           |             |                        |                             |     |
| × ×                 | hysic<br>his ca<br>Il dire   | -<br>-<br>-      | 1 Yes 2 No   |                            |   | ER/Outpatier                            |   |                         | 4 NU              |                 | me 5 ☐ Resi                     |               |             | (Specify)              |                             |     |
| Ē                   | ding Phys<br>h.<br>After this<br>funeral dir   |                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  |                            | of Injury<br>oth, Day Year)             | 28b. Time o<br>Injury                   |   | 8c. Injury<br>Work      |                   |                 | 28d. Describe                   | how injury    | occurred    |                        |                             |     |
| Sio                 | tend<br>leath.<br>tor: /<br>the fi   | cati             | 2 Accident investigatio  |                            |   |   | M                                       |                         | /es 2 □           |                 | 001  +                          | Otrock on d   | \$ 1 to     | D / D                  |                             |     |
| Division or         | l or Attendatter death<br>Director:  | Certification:   | 4 ☐ Homicide determined  | 20e. Flat                  | e of injury - At h<br>ling, etc. (Speci | fy)                                     | eet, ractory                            | , once                  |                   |                 | 28f. Location (<br>City or To   | wn, State)    | Number (    | or Hurai H             | oute ivumber,               |     |
|                     | ppital<br>ours a<br>peral I  |                  | 29a. Certifier 1 <b>Certifying P</b> i   | vsician: To th             | e best of my kno                        | owledge, deat                           | h occurred                              | at the tim              | ne. date ar       | nd place.       | and due to the                  | cause(s) a    | and mann    | er as state            | ed.                         | _   |
|                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,   | Medical          | (Check only 2 Medical Exa  | miner: On the I            |   |   |   |                         |                   |                 |                                 |               |             |                        |                             |     |
|                     | ro th<br>vithin<br>ro th   | Me               | 29b. Signature and title of certifier  | 0 10                       |   |   | 290                                     | . License               | number            |                 |                                 | 29d. Date     |             | Month, Day             | y, Year)                    | _   |
|                     |  |                  | Lovern   | Kuth                       | umo                                     | me                                      |   | D5                      | 95                | 24              |                                 | Mar           | ch          | 31,                    | 2008                        |     |
| 7                   |  |                  | 30. Name and address of person who   | completed cau              | se of death (Iter                       | m 23a) (Type,                           | Print)                                  |                         |                   |                 |                                 |               |             |                        |                             | _   |
| _                   |  |                  | LOVEEN J. PUTH   | MMA                        | 1A,311                                  | 0 GRA                                   | CEFIE                                   | LD                      | KOAD              | 1,5             | ILVER S                         | PRI           | NG          | MD                     | 20904                       | _   |
|                     | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)<br>APR 1 0 200   | 18                         | Registrar's Sign                        | ature                                   | de                                      |                         |                   |                 |                                 |               | ,           |                        |                             |     |

DHMH 17 Rev 1/2001

|   |                  | Please Type or Pri State of M  1 - State Registrar   | laryland / Dep                                    |  | h and Mental Hyg  |   |
|---|------------------|--|---|--|---|---|
| Physici<br>/Medi<br>Examir  | cal              | Decedent's Name (First, Middle, Last)     OPAL C RAP      A. Facility Name (If not institution, give street and number)                                    | )   | 4b. City, Town, or Locat   | 2. Date of Dea<br>Month<br>MARCH                                      | Day Year 29 2008 6 - ZoA M  4c. County of Death                                   |
| Funeral<br>Director   | r                | Ellicott City Health & Rehab C  5. Social Security Number 307-20-3170 6. Sex 1 M 2 DF 7. A   | ge (In yrs. last birthday)<br><b>84</b> Yrs.      |  | ott City  Ider 24 Hrs.  B. Date of Birth  In Min.  Month, Day  Dec 16 | Howard  9. Birthplace (State or Foreign Country) Fla                              |
| e Maryland<br>te-f show   | ctor             | Usual Residence of Decedent  10a. State  | 10c. City, Town or L                              |  | umbia   | 10d. Inside City Limits 1 ☐ Yes 2☐No  |
| h with th   | al Director      | 10e. Street and Number 6437 Snuffbox Terr.   |   | 10f. Zip Code <b>21</b>  | 1044  | 10g. Citizen of What Country? U.S.A.  |
| n 72 hours after death with the Maryland<br>n 72 hours after death with the Maryland<br>"naturel", or Items 23e or 28e-f show<br>grifted Examinet must be notitied at | by Funeral       | 11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Deceden Armed Forces 1 Yes 20 1 Fyes, Give Year or Dates:                               | <b>%</b> o  | Was Decedent of Hispanic<br>If Yes, specify Cuban, Mex<br>1 Yes 2 No Spe   | c Origin? (Specify Yes or No-<br>kican, Puerto Rican, etc.)           | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: Black               |
| within 72 ho<br>jiene.<br>r then "natur<br>rhs Medical  | Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 2)  | 5+) 16a. Dece<br>(Give<br>life.                   | edent's Usual Occupation<br>e kind of work done during<br>DO NOT use retired)<br>Homemal   |   | 16b. Kind of Business/Industry  Own Home  |
| be filed<br>hal Hyg<br>ad othe  | To Be Co         | 17. Father's Name (First, Middle, Last)  Mann Neniver  | Perry   | 18. M  | lother's Name (First, Middle,<br>Car                                  | Maiden Sumame) rie Douglas  |
| ges 1 and 2 should<br>t of Health and Mer<br>If item 27 le marke<br>or other treumatic  |                  | 19a. Informant's Name/Relationship (Type, Print)  Gabrielle Myrick   |   |  | olumbia, MD 21044   | r, City or Town, State, Zip Code)<br>1  |
| T it e a  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  | Bayvie  | w Crematory  | Apr 02, 2008  | 20c. Location - City or Town, State  Baltimore, MD                                |
| pernit. Dep-rtm Imp-rte any inju  |                  | 21. Signature of Funeral Service Licensee  | 101793  | 2. Name and Address of F<br>Slack Funeral<br>3871 Old Colu   | <sup>acility</sup><br>Home, P.A.<br>mbia Pike Ellicott City           | y, MD 21043   |
| Physician   |                  | 23a. Part1. Fer the difference of complications the cause shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition | od the death. Do not en<br>line.                  |  |   | Onset and Death   |
| /Medical<br>Examiner  | L                | 0-10   | s a consequence of):  STIVE s a consequence of):  | HEART  | FAILURE   | noneti  |
| te be executed ysician and le burial-transit  | Examiner         | cause. Enter Underkying Cause (Disease or injury that initiated events resulting in death) Last  | CINOMA s a consequence of):                       | OFIN   | TESTINE   | s unknown   |
| ificate b<br>g physic<br>as the br  | edical           | d  | PERTEN  | 310N   |   |   |
| w requires that the death certificate been signed by the attending phys should be detached for use as the   | Physician/Medi   |  | 2 ☐ Fetal death 3 [                               | □Ectopic pregnancy □ Other (specify)   |   | 23d. Date of delivery<br>Month Day Year   |
| requires that the   | þ                | Part II. Dther significant conditions contributing to death  |   |  |   | bacco use contribute to the cause of death?<br>es 2 □ No 3 □ Probably 4 □ Unknown |
| The larate has  | Completed        |  |   |  | 24a. Was a autop: perfor 1 Yes  | sy prior to completion of cause of  |
| 09  | o Be             | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpat  | ient 2□ER/Outpatie                                | Other  | Place of Death (Check only or<br>Mursing Home 5 Resid                 |   |
| ding<br>h.<br>After<br>fune   | Certification: T | 27. Manner of Death  Natural 5 Pending (Month, D)  2 Accident investigation  3 Suicide 6 Could not be  | ay Year) Injury                                   | of 28c. Injury at Work?  M 1 \( \triangle \tri | 28d. Describe h<br>2 □ No   | ow injury occurred  |
| Unto the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune funerel.                                  | Certifi          | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, €   | njury - At home, farm, sl<br>tc. <i>(Specify)</i> | treet, factory, office   | 28f. Location (S<br>City or Tow                                       | itreet and Number or Rural Route Number,<br>m, State)                             |
| To the Hospitel or<br>within 24 hours af<br>To the Funerel D<br>completely filled in  | edical           | 29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner s  | of examination and/or in                          | th occurred at the time, dat<br>nvestigation, in my opinion,   | e and place, and due to the c<br>death occurred at the time, c        | cause(s) and manner as stated.  date and place, and due to the cause(s)           |
| To th<br>Withir<br>To th  | Me               | 29b. Signature and title of certifier  |   | 29c. License numl  |   | 29d. Date signed (Month, Day, Year)   |
| 12  |                  | 30. Name and address of person who completed cause of  | death (Item 23a) (Type                            | Print)   | 0100  | NARCH 29 200 8  |
| Sta   | ate              | 31. Date filed (Month, Day, Year)  32. Regis   | trar's Signature                                  | 630 3 HN   | TITLO   | SUITE 110<br>COLUMBIA<br>NO MOUS  |
| Regist  | rai              | APR 1 0 2008   | J. Spa  | MES  |   |   |

DHMH 17 Rev 1/2001

EVIN RUFFINS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 7, 2008 0045 hrs Ruffins Medical Examiner Kevin 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Country) Days Months Hours Min Director 219-08-0824 21 85 MD 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location any 10a. State 1 X Yes 2 No N/A Baltimore MD 28a-f show s 23a or 28a-f show notified at once. the Maryland 10f, Zip Code 10g. Citizen of What Country 10e. Street and Number 5265 Cedgate Road 21206 USA ö 펻 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. , or items Funer White, etc Armed Forces? 1 X Never Married 2 X No Yes Black Yes 2 X No specify: Specify: more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after nen of Health and Mental Hygiene. If Yes, Give Year Widowed Divorced other traumatic event, the Medical Examiner "natural" à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 12th marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tonya Warren Α. Ruffins Sr. Grant Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 is Baltimore, MD 5265 Cedgate Rd. Blondell Dunaway-grandmother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Pk 4/12/2008 MD Randallstown ant: Donation 5 Other Specify: ò 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST MD 21202 1101 E. North Avenue Baltimore, 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transil hysician/Medical AMENDED UNPENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 面 þ Yes 2 ✓ No 3 Probably 4 Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No Yes 2 page 26.Place of Death (Check only one) 25. Was case referred to medical director, Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 🗸 Inpatient Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this 1 ✓ Yes No funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Apr 6, 2008 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot by police Certification: 2216 hrs Natural Yes 2 🗸 No filled in by the f Pending after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 3100 block Mcelderry Street, Baltimore, MD determined 24 hours a (Specify) Local Street 4 Momicide 29a. Centifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of dertifier April 7, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 11:23 A<sup>M</sup> Margaret Richardson 2008 Anna April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 217 Booth Street Montgomery Co. Apt. 318 Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Hours Days 1 □ M 2 🛣 F Months **Director** 63 March 27,1945 Washington, 220-42-1372 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at Director Gaithersburg 1 ☐ Yes 2X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 318 217 Booth Street United States Funeral 20878 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ins. Once. Private Practice Social Worker-LCSW 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Regina Graebenstein ဂ John Dugan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21207 Megan K. Richardson (Daughter) 5102 Maple Park Ave. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/11/2008 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cem. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licens 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heratitis C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Liver Disease Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Dementia (mild) Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ned by the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ sign Migraine Headaches 1 ☐ Yes ¾XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? law 24a. Was an Osteupenia cate has page 2 s autopsy performed? Yes 21 No certificate | 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes Progressive Spinal Deformity To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number INV m() DOOS4843 and address of person who completed cause of death (Item 23a) (Type, Print) 15005 Shadey Grove Road Suite 410 Rockville, MD 20850 David Charles, M.D. 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 0 2008 Registrar

State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 3 Karen Scarborough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale HOSPITAL Center FRANKLIN SQUARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F Mar 31, Director 65 219-40-9761 Usual Residence of Decedent 10h County 10c. City, Town or Location notified a Director MD Baltimore Baltimore 28a-f the 10e. Street and Number 10f Zin Code 10a. with ō must be 21237 6600 Ridge Road 23a death ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b College (1-4or 5+) Elementary/Secondary (0-12) Scarborda unk f Health and Mental Hy, unk 18. Mother's Name (First, Middle, Maid 17. Father's Name (First, Middle, Last) Be ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, Cit 19a. Informant's Name/Relationship (Type. Print) 9000 Franklin Square Drive Balt Franklin Square Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Renald Wave, 21. Signa State Anatomy Board 655 W. Bard n Baltimore, MD 21201 23a. Part 1. Enter the disease or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Infacction Physician Acute myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacc Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. . 13 centimeter abdominal A 1 □ Yes Completed 24a. Was an End COPD Stage Renal autopsy performe ba modialysis To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA ို this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how i Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street City or Town, S. 4 Homicide n 24 hours af ie Funeral Di eletely filled i 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caus 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | State o  | f Marylan   |                                  | rtment of H<br>tificate of I   |                           |                        | fiental H                           | ygiene<br>Reg. No.            | 008                             | 11704  |
|--|--|---|----------------------------------|--|---------------------------|------------------------|-------------------------------------|-------------------------------|---------------------------------|--|
| (First, Middle, La                                       | ast)   |   |                                  |  |                           |                        | 2. Date of D                        | eath                          | Vaaa                            | 3. Time of Death                                 |
| arborous   | gh   |   |                                  |  |                           |                        | Month<br>3                          | 3 <i>i</i>                    | Year 2008                       | 2:416 AM   |
| not institution, gi                                      |  | mber)   |                                  | 4b. City, Town, or   | Location                  | of Death               |                                     | 4c. C                         | ounty of Deat                   |  |
| Square   | HOSPITI  | AL Cen  | Ter                              | Rosed  |                           |                        |                                     | 13                            | aLTIM                           | nore   |
| 761 6.5  | Sex<br>1 □ M 2 <b>X</b> F                        | 7. Age (In yrs. i                                     |                                  | If Under 1 Year<br>Months Days   | If Under<br>Hours         | Min.                   | 8. Date of B<br>(Month, I<br>Mar 31 | Day, Year)                    | Co                              | hplace (State or Foreign<br>untry) unk           |
| Decedent   |  | 10c City  | , Town or Loc                    | cation   |                           |                        |                                     |                               |                                 | 10d. Inside City Limits                          |
| 10b. County  |  | 100. 010  |                                  |  |                           |                        |                                     |                               |                                 | 1 □ Yes 2√□ No                                   |
| Baltim   | ore  |   | Baltin                           |  |                           |                        |                                     | 100 Cini-                     | of What C-                      |  |
| nber<br>dan Road   |  |   |                                  | 10f. Zip Code<br>212   | 37                        |                        |                                     | _                             | en of What Co<br>SA             | randy:   |
| dge Road   | 7  | edent Ever in U.                                      | S 13 V                           |  |                           | rigin? (Sr             | ecify Yes or N                      |                               | 1. Race - Ame                   | rican Indian,                                    |
| ed 2 ☐ Married   | Armed For 1 Yes If Yes, Gir Year or D            | orces?<br>2011 No<br>ve                               |                                  | Vas Decedent of H<br>f Yes, specify Cuba<br>□ Yes 2][ No   | Specify                   |                        | Rican, etc.)                        |                               | Black, White                    | e, etc.  |
| 15. Decedent's E<br>ify only highest gi                  | rade completed) College (                        |   | 16a. Deced<br>(Give )<br>life. D | lent's Usual Occup<br>kind of work done<br>OO NOT use retired  | ation<br>during mo<br>d)  | st of work             | unk<br>king                         | 16b. Kind                     | d of Business/                  | Industry un                                      |
|  | ınk  |   |                                  | 1151   | 18 Moth                   | er'e Nam               | e (First, Midd                      | lle Maiden S                  | urname)                         | u  |
| First, Middle, Las                                       | i)   |   |                                  | uns  | to, iviotr                | нег э гуап             | e (First, MIGO                      | ie, ivialueli S               | шпаше)                          | U  |
| me/Relationship<br>Square                                | (Type. Print)<br>Hospita                         | 1   |                                  | g Address (Street<br>Franklin  |                           |                        |                                     |                               |                                 | · - '  |
| osition  Cremation 3 [ 5 \times Other (Spec              |  |   | lace of Dispos<br>emetery, cren  | sition (Name of<br>natory or other place   | ce)                       |                        | Date                                | 20c. Loca                     | ation - City or                 | Town, State                                      |
| neral Service Lice                                       |  | irector   |                                  | Name and Addre<br>ate Anat<br>ltimore,   | _                         |                        |                                     | . Balt                        | imore                           | Street   |
| t failfure. List only final ditions, mediate lying njury | a. A CCC Due to b. Due to c.                     | _   | ence of):                        | dial I   | nfa                       | rc T                   | 101                                 |                               |                                 | Interval Between Onset and Death 3 hours         |
| pregnant months?   | 1□Live   | itcome pf pregna<br>birth 2□Feta<br>nant at time of d | Ideath 3□                        | Ectopic pregnanc   | у                         |                        |                                     | 23                            | 3d. Date of del                 | livery<br>Day Year                               |
| No   | 9□Unkn   |   |                                  |  |                           |                        |                                     |                               |                                 |  |
| cant conditions  | contributing to d                                | leath but not res                                     | ulting in the ur                 | nderlying cause giv  | en in Part                | 1.                     | 23e. Di                             | d tobacco us                  | e contribute to                 | the cause of death?                              |
| ZA A   | 13 cen   | TimeTe  | r abd                            | lominal  | gor                       | Tic                    | 1[                                  | ∃Yes 2□                       | No 3□Pi                         | robably 4 Honknown                               |
| n COP  |  | Stage   | : Ren                            | al dise  | رد د                      | On                     | pe                                  | topsy<br>rformed?_            | prior to death?                 | utopsy findings available completion of cause of |
| red to medical   | 1. V, A  |   |                                  |  | 26 Bloc                   | ne of Don              | th (Check onl                       |                               | 1 ∐Yes                          | 3 2 □ No   |
| Vo   | Hospital: 1                                      | Inpatient 2□  | ER/Outpatien                     | t 3 DOA Oth  | or.                       |                        |                                     |                               | ☐Other (Spe                     | ecify)   |
| 5 □ Pending investigation                                | 28a. Date<br>(Mor                                |   | 28b. Time of<br>Injury           | 28c. Inju  |                           |                        |                                     | e how injury                  |                                 | ony/   |
| 6 ☐ Could not determined                                 | be 28e. Place                                    | e of injury - At ho<br>ling, etc. <i>(Specif</i>      | ome, farm, stre                  | eet, factory, office   |                           | *******                |                                     | n (Street and<br>Town, State) | Number or R                     | ural Route Number,                               |
| 1  | Physician: To the<br>aminer: On the t<br>and mar | e best of my kno<br>basis of examina<br>nner stated.  | wledge, death<br>tion and/or in  | n occurred at the ti<br>vestigation, in my   | me, date a<br>opinion, de | and place<br>eath occu | e, and due to the time              | ne cause(s) ane, date and     | and manner as<br>place, and due | s stated.<br>e to the cause(s)                   |
| title of certifier                                       | W.   | m   |                                  | 29c. Licens  | se number                 |                        |                                     |                               | signed (Mont                    | th, Day, Year)                                   |
| ess of person who  | o completed cau                                  |   |                                  | Print)   |                           |                        | - DR                                | Bal                           | LTO M                           | 1d 21237   |
| h, Day, Year)  | 32.1   | Registrar's Sig                                       |                                  | the state of the s |                           |                        |                                     |                               |                                 |  |

State Registrar

Medical

DR Cassandra 31. Date filed (Month, Day, Year)  $\Delta PR = 1 \quad V \quad 2008$ 

within 24

SEROPER

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|   | 1                      | For<br>State<br>Registrar   | State of Ivial                                  | -                   | Certificat                          |                  |  |  | Reg. No.                   |                                   |   |
|---|------------------------|---|---|---------------------|-------------------------------------|------------------|--|--|----------------------------|-----------------------------------|---|
| S. O.   |                        | 1. Decedent's Name (First, Middle, Las  | 1)  |                     |                                     |                  |  | Date of De     Month                   | ath<br>Day                 | Year                              | 3. Time of Death                            |
| Physici<br>/Medi  |                        | VIRGINIA L.   | SIMS  |                     |                                     |                  |  | APRIL                                  | 2                          | 2008                              | 8:08 A                                      |
| Examir  |                        | 4a. Facility Name (If not institution, give   | street and number)                              |                     | , ,                                 |                  | Location of Death                          |  |                            | ounty of Death                    |   |
|   | A Contract             | 9500 PRINCE WILLI   | AM DRIVE  |                     |                                     | NDYW.            |  | ,                                      |                            | INCE GE                           |   |
| Funeral   |                        | 5. Social Security Number 6. S  |   | (In yrs. last birth | Months                              | r 1 Year<br>Days | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Bir<br>(Month, Da           | ay, Year)                  | Cor                               | nplace (State or Fore<br>untry)             |
| Director  |                        | 238-70-8256 Usual Residence of Decedent   | □M 2XIF 65                                      | Y                   | rs.                                 |                  |  | March 2                                | 1, 194                     | 43   NC                           |   |
| land<br>ow<br>It  |                        | 10a. State 10b. County  |   | Ioc. City, Town     | or Location                         |                  |  |  |                            |                                   | 10d. Inside City Lim                        |
| Mary<br>f sho   | ö                      | MD PRINCE G   | EORGE! S  | BRANDY              | WINE                                |                  |  |  |                            |                                   | 1 □ Yes 2 💢                                 |
| the 28a   | rec                    | 10e. Street and Number  |   |                     | 10f. Zi                             | p Code           |  |  | 10g. Citiz                 | en of What Co                     | untry?                                      |
| with yard   | Ö                      | 9500 Prince Willi   | am Drive  |                     | 2                                   | 0613             |  |  | USA                        |                                   |   |
| eath  | era                    | 11. Marital Status  | 12. Was Decedent Ev                             | er in U.S.          | 13. Was Dece                        | dent of H        | ispanic Origin? (Sa<br>an, Mexican, Puert  | pecify Yes or N                        | o- 1                       | 4. Race - Ame<br>Black, White     |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  once. | y Funeral Director     | 1 XNever Married 2 Married  | Armed Forces? 1 ☐ Yes 2 X No If Yes, Give       | )                   |                                     |                  | Specify:                                   | o rican, etc.)                         |                            |                                   | Lack  |
| within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>ha Medical Examiner must be notified at  | Completed by           | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed   | Year or Dates:                                  | 16a.                | Decedent's Usi                      | ual Occup        | ation                                      | kina                                   | 16b. Kin                   | d of Business/                    |   |
| nin 72<br>n "na<br>Medil  | ple                    | (Specify only highest gra   | College (1-4or 5+                               | )                   | life. DO NOT                        | ise retired      | during most of wor<br>f)                   | iong                                   |                            |                                   |   |
| i with  | E                      | Elementary/Secondary (6 12)   | 6   | Ass                 | istant                              | Prin             | cipal                                      |  | P. G                       | . Count                           | y Schools                                   |
| Hygi<br>Hygi<br>other<br>ent, tl  | Be C                   | 17. Father's Name (First, Middle, Last,   |   |                     |                                     |                  | 18. Mother's Nan                           | ne (First, Middle                      | e, Maiden S                | Surname)                          |   |
| id be<br>ental<br>ked c   | To B                   | Johnny Lee Sims   |   |                     |                                     |                  | Margare                                    | t Lumpk                                | in                         |                                   |   |
| 2 should<br>and Men<br>Is marke<br>raumatic   | 1                      | 19a. Informant's Name/Relationship (  | Type. Print)                                    | 19b.                | Mailing Address                     | s (Street        | and Number or Ru                           | ıral Route Num                         | ber, City or               | Town, State, 2                    | Zip Code)                                   |
| and 2<br>ealth a<br>n 27 Is<br>ier trau   |                        | Bernita Sims  |   | 17                  | 20 Cano                             | llewo            | od Court                                   | High                                   | Point                      | , NC 2                            | 7265  |
| Hea<br>Hea<br>Hem   |                        | 20a. Method of Disposition  |   | 20b. Place of       | Disposition (Na<br>y, crematory or  | me of            | ce)  | Date                                   | 20c. Loc                   | cation - City or                  | Town, State                                 |
| nt of<br>nt of<br>nt of   | II.                    | 1 M Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Special   |   |                     | gton Na                             |                  | 1 - 1                                      | 7-2008                                 | Suit                       | land,                             | MD  |
| rtme<br>rtani<br>njur)  | 1                      | 21. Signature of Funeral Service Lice   |   | Wasiiiii            |                                     |                  |  |  |                            |                                   | OME OF MD                                   |
| permit. Page Department of Important: If any injury or once.  |                        | DR. DX  | DONADE  | /                   | 4308                                | SUIT             | LAND ROA                                   | D SUIT                                 | LAND,                      |                                   | 0746  |
|   |                        | 23a. Part I Inter the diseas i, over meant failure. List only   | plications that caused                          | the death. Do n     | not enter the mo                    | ode of dyin      | ng, such as cardia                         | c or respiratory                       | arrest,                    |                                   | Approximate<br>Interval Between             |
| Physician   |                        | Immediate Cause (Final  | A4= - A ST                                      | A c                 | 157.10                              | F 4              | 1 A /3//31 3//1A 7                         | 6 Lu                                   | 06 B                       | ONE.                              | Onset and Deatl                             |
| /Medical  |                        | disease or condition resulting in death)  | a. METAST  Due to (or as a                      | consequence         | of):                                | LUG              | R  |  | 0 0                        |                                   | 3   |
| Examiner  |                        |   |   |                     | ,                                   |                  |  |  |                            |                                   |   |
| -47 <b>3</b> -  | ē.                     | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a                              | consequence         | of):                                |                  |  |  |                            |                                   |   |
| ist 🕢 te  | Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |                     |                                     |                  |  |  |                            |                                   |   |
| Attending Physician: The law requires that the death certificate be executed refath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit   | Xal                    | resulting in death) Last  | c<br>Due to (or as a                            | consequence         | of):                                |                  |  |  |                            |                                   |   |
| be e<br>ician<br>buria  | <u>a</u>               |   | St.   |                     |                                     |                  |  |  |                            |                                   |   |
| phys<br>the   | edical                 | **  | d   |                     |                                     |                  |  |  |                            |                                   |   |
| eath certificate be executed attending physician and for use as the burial-transit  |                        | IF FEMALE:  | 23c. If yes, outcome                            | of pregnancy        |                                     |                  |  |  | 2                          | 23d. Date of de                   | elivery                                     |
| atten<br>atten<br>for u   | Physician/N            | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐Live birth<br>4 ☐Pregnant at                 | 2 □Fetal death      | 3 □Ectopic<br>5 □ Other (           |                  | У  |  |                            | Month                             | Day Year                                    |
| at the de<br>by the a<br>tached   | /sic                   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□Unknown                                       |                     |                                     | -,,/_            |  |  |                            |                                   |   |
| d by<br>letac   | F.                     | Part II. Other significant conditions   | contributing to death bu                        | t not resulting in  | n the underlying                    | cause giv        | ven in Part I.                             | 23e. Did                               | i tobacco u                | se contribute t                   | to the cause of death                       |
| res tha<br>signed b   | b                      | , alt in Guite and  | J   |                     |                                     |                  |  | 10                                     | ]Yes 2[                    | 1<br>1 No 3 □ F                   | robably 4 □Unki                             |
| w require<br>been się<br>should b   | Completed              |   |   |                     |                                     |                  |  |  |                            | l ou w                            | A findings                                  |
| e law l<br>has be   | 릥                      |   |   |                     |                                     |                  |  | 24a. Wa                                | is an<br>topsy<br>rformed? | prior to<br>death?                | utopsy findings avai<br>completion of cause |
| The I   | 0                      |   |   |                     |                                     |                  |  |  | 2 No                       | 1 ☐ Ye                            | s 2□No                                      |
| i <b>lcian:</b> Th<br>certificate<br>ector, pag   | Be                     | 25. Was case referred to medical examiner?  |   |                     |                                     |                  | 26. Place of De                            | ath (Check onl                         | / one)                     |                                   |   |
| Physic<br>this ce<br>al direc   | 0                      | 1 ☐ Yes 2 No  | Hospital: 1 ☐ Inpatie                           | nt 2 ☐ ER/Ou        | utpatient 3                         | DOA Ot           | her: 4 Nursing                             | Home 5 🛛 Re                            |                            |                                   | ecify)                                      |
| ding Ph<br><br>After th<br>funeral  | Ë                      | 27. Manner of Death   | 28a. Date of Injui                              |                     | Time of<br>Injury                   | 28c. Inju        | ıry at<br>ork?                             | 28d. Describ                           | e how injur                | y occurred                        |   |
| ndin<br>ath.<br>r: Af   | atio                   | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation  | n   |                     | М                                   |                  | ]Yes 2 □ No                                |  |                            |                                   |   |
| • Attend<br>er death<br>rector: /<br>by the f   | <u>:</u>               | 3 ☐ Suicide 6 ☐ Could not l<br>4 ☐ Homicide determined  | 28e. Place of injubuilding, etc.                | ry - At home, fa    | arm, str <i>ee</i> t, fact          | ory, office      |  | 28f. Location<br>City or 1             | (Street an<br>Town, State  | d Number or F                     | Rural Route Number                          |
| al or<br>afte<br>I Dir<br>d in I  | ert                    |   | ł   |                     |                                     |                  |  |  |                            |                                   |   |
| To the Hospital or Attenc<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the   | Medical Certification: | (Check only 2 Medical Exa   | hysician: To the best of miner: On the basis of | examination ar      | e, death occurr<br>nd/or investigat | ed at the i      | time, date and place<br>opinion, death occ | ce, and due to to<br>curred at the tim | ne cause(s<br>ne, date an  | ) and manner a<br>d place, and di | as stated.<br>ue to the cause(s)            |
| the l   | led                    | one)  | and manner sta                                  | nea.                | 1                                   | 29c. Licen       | se number                                  |  | 29d Da                     | te signed (Mor                    | nth, Day, Year)                             |
| Vitt<br>Con   | 2                      | 29b. Signature and title of certifier   |   |                     | ,                                   |                  |  |  |                            |                                   |   |
| 1   |                        | Matilda   | H. 50,1   | w _                 |                                     | D                | 2625                                       | 0                                      | _ C                        | 14/03/                            | 2008  |
| n   |                        | 30. Name and address of person who  | completed cause of d                            | eath (Item 23a)     | (Type, Print)                       |                  |  |  | ~                          |                                   |   |
|   |                        | MATILDA SO . 13   | ZI MERCH  | NTILE               | LANT                                |                  | LARGO,                                     | MD.                                    | 20                         | 774.                              |   |
| S   | tate                   | MATILDA SO 31. Date filed (Month Day, Year)   | 107   | ar's Signature      | board                               | 20               | LAKGO                                      | MD.                                    | 20                         | 117.                              |   |

DHMH 17 Rev 1/2001

| )  | J. | MI | 5   | ,          |    |
|----|----|----|-----|------------|----|
|    | ı  | R  | egi | Sta<br>str |    |
| DH | МН | 17 | Rev | 1/2        | 00 |

|                             | State Registrar  1. Decedent's Name  | (First, Middle, Las   | st)  | <u> </u>  | ertificate of   | Death                                    | Reg                                  | g. No. 2008                                | 3. Time of Death                                   |
|-----------------------------|--|---|--|---|---|--|--------------------------------------|--|--|
| an                          | ANNE   | RUTH  | SMITH  |   |   |  | Month<br>APRIL                       | Day Year 2008                              | 7:30 A   |
| cal<br>ner                  | 4a. Facility Name (If r  | not institution, give   | e street and number)   |   | 4b. City, Town, o   | or Location of Death                     |                                      | 4c. County of Deat                         |  |
|                             | KENSINGTO  | ON NURSI  | NG & REHAB   | ILITATION   | N KENSIN  | GTON                                     |                                      | MONTGOME                                   | RY   |
|                             | 5. Social Security Nur   |   | ex 7. Age  | e (In yrs. last birthd  | Months Days   |  | 8. Date of Birth<br>(Month, Day,     | 9. Birt<br>Yea <i>r</i> ) Co               | hplace (State or Forei<br>untry)                   |
|                             | 579-34-35  | 502   | 8  | 3 Yrs   |   |  | DEC 11                               |  | th Carolir   |
|                             | Usual Residence of D   | 10b. County   |  | 10c. City, Town or  | Location  |  |                                      |  | 10d. Inside City Limi                              |
| ţo                          | MD   | Montgome  | arw  | Kensing   | rton  |  |                                      |  | 1∭TYes 2□N   |
| Director                    | 10e. Street and Numb   |   | CIY  | Kensing   | 10f. Zip Code   |  | 10                                   | g. Citizen of What Co                      | untry?   |
| al                          | 3000 McCo  | omas Ave  | nue  |   | 20895   |  |                                      | USA  |  |
| Funeral                     | 11. Marital Status   |   | 12. Was Decedent B<br>Armed Forces?  | Ever in U.S.  | 3. Was Decedent of I  | Hispanic Origin? (Spoan, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Ame<br>Black, White             |  |
| by F.                       | 1 Never Marrie   |   | 1 ☐ Yes 2 📉 N<br>If Yes, Give  | 10  | 1 □Yes 2 ∏ No   |  | Thousand Story                       | Specific                                   |  |
| δ<br>D                      | 3 X Widowed 4  |   | Year or Dates:   | 40. B   |   |  |                                      | В.   | 1ack   |
| Completed                   | (Specif  | 15. Decedent's Ed<br>fy only highest gra  | lucation<br>ide completed)   | 1 (6  | ecedent's Usual Occu<br>live kind of work done<br>le. DO NOT use retire | during most of work                      | ing                                  | 6b. Kind of Business/                      | industry   |
| E O                         | Elementary/Second  | dary (0-12)   | College (1-4or 5   | +)  | csing Assi  | ,  |                                      | Private In                                 | dustrv   |
| a                           | 17. Father's Name (F   | First, Middle, Last)  | I  | 110   | DING HOUL   | 1  | e (First, Middle, Ma                 |  |  |
| To B                        | Jessie Ke  | emp   |  |   |   | Mattie                                   | Blocker                              |  |  |
| -                           | 19a. Informant's Nan   | me/Relationship (   | Type. Print)   | 19b. M  | ailing Address (Stree   | t and Number or Rui                      | al Route Number,                     | City or Town, State, 2                     | Zip Code)  |
|                             | Sandra Si  | mith / D  | aughter  | 91  | 18 Susan L  | ane Clin                                 | ton, MD                              | 20735                                      |  |
|                             | 20a. Method of Dispo   |   | D  | 20b. Place of Di<br>cemetery,                                   | sposition (Name of<br>crematory or other pla                            |  | Date 2                               | 0c. Location - City or                     | Town, State  |
|                             |  | 5 $\square$ Other (Specify  | Removal from State  y)   | Cedar H   | ill Cemete  | ry 04-1                                  | 1-2008                               | Suitland,                                  | MD   |
|                             | 21. Signature of Fun   | teral Service Licen   | isee   |   | 22. Name and Addr   | ess of Facility MA                       | RSHALL'S                             | FUNERAL H                                  |  |
|                             | ) (K   | · /   | upis e (RA)  |   |   | ITLAND RO                                |                                      | TLAND, MD                                  | 20746  |
|                             | 23a. Par 4 Enter the shock, or heart   | e diseas , or comp<br>t failur . List only  | plications that caused<br>one cause on each lir  | th death. Do not<br>ne.   | enter the mode of dy  | ing, such as cardiac                     | or respiratory arre                  | st,  | Approximate<br>Interval Between<br>Onset and Death |
|                             | Immediate Cause (F<br>disease or condition<br>resulting in death)  |   | a CHRO   | NIC OF  | BSTRUCTU  | VE PUL                                   | MONTA                                | y DISEA                                    | 16   |
|                             | resulting in death)  |   | Due to (or as  | a consequence of):  |   |  |                                      |  |  |
| ē                           | Sequentially list cond   | ditions,  | b. Due to fix no   | a ounsequence of):  |   |  |                                      |  |  |
| Examiner                    | cause. Enter Underly<br>Cause (Disease or in   | lying<br>njury  | ,  | ,   |   |  |                                      |  |  |
| Exa                         | that initiated events<br>resulting in death) La  | ast .   | Due to (or as  | a consequence of):  |   |  |                                      |  |  |
| cal                         |  | - L   | d  |   |   |  |                                      |  |  |
| Medi                        | IF FEMALE:   |   |  |   |   |  |                                      |  |  |
| an/I                        | 23b. Was decedent p  |   | 23c. If yes, outcome<br>1 ☐ Live birth   | of pregnancy<br>2 ☐ Fetal death                                 | 3 ☐ Ectopic pregnan   | су                                       |                                      | 23d. Date of de                            | livery<br>Day Year                                 |
| Sici                        | 1 ☐ Yes 2 ☑<br>9 ☐ Unknown   |   | 4 ☐ Pregnant a<br>9 ☐ Unknown  | t time of death   | 5 Other (specify)   |  |                                      | WORUS                                      | Day Teal   |
| Physician/Medical           |  | cant conditions o   | ontributing to death be  | it not regulting in th  | a underlyina cause ai   | ivan in Part I                           | 23e Did tob                          | acco use contribute to                     | the cause of death?                                |
| ò                           |  | ABETE   | 0  | at not resulting in th  | e underlying cause gi   | wer iii i ait i.                         | 1 ☐ Yes                              |  | robably 4 🗆 Unkno                                  |
| etec                        |  | NUELU   |  |   |   |  |                                      |  |  |
| _                           |  |   |  |   |   |  | 24a. Was an<br>autopsy<br>perform    | prior to                                   | topsy findings availa<br>completion of cause       |
| 랍                           | 05.14/   |   | -  |   |   |  | 1 ☐ Yes 2                            | ∑HNo 1 ☐ Yes                               | 2 Dinio  |
|                             | 25. Was case referre examiner? 1 ☐ Yes 2 ☑ 🕅   | i   | Hospital:  |   | ot Ot   | her:                                     | h (Check only one                    | · · · · · ·                                |  |
| Be                          | 1 162 Z  |   | 28a. Date of Inju  | ry 2 ER/Outpa   | tilent 3 DOA  | great Nursing He                         | ome 5 ☐ Resider<br>28d. Describe how | nce 6 Other (Spe<br>w injury occurred      | ecify)   |
| To Be                       | 27. Manner of Death  | 5 Pending   | (Month, Day  | y, <i>Year)</i> Inju  | ry Wo   | ork?<br>⊒Yes 2⊡No                        |                                      |  |  |
| To Be                       | 1 🔀 Natural  | investigation   |  | ury - At home, farm   | street, factory, office   |  | 28f. Location (Str.<br>City or Town, | eet and Number or Ri                       | ural Route Number,                                 |
| To Be                       | 1 Matural<br>2 ☐ Accident<br>3 ☐ Suicide   |   | 28e. Place of Inju   | , (Opecity)   |   | Į.                                       | City of Town,                        | Siate)                                     |  |
| To Be                       | 1 Matural<br>2 ☐ Accident  | investigation<br>6 ☐ Could not be   | 28e. Place of Injubuilding, etc  |   |   |  | and due to the co                    | use(s) and manner a                        |  |
| Certification: To Be        | 1 Natural 2 Accident 3 Suicide 4 Homicide  | investigation  6 Could not be determined  | building, etc  | of my knowledge, o  |   |  |                                      |  |  |
| Certification: To Be        | 1 Natural 2 Accident 3 Suicide 4 Homicide  | investigation  6 Could not be determined  | building, etc  | of my knowledge, of examination and/o                           | or investigation, in my   | opinion, death occur                     | red at the time, da                  | ite and place, and due                     |  |
| To Be                       | 1 Natural 2 Accident 3 Suicide 4 Homicide  | investigation  6  | building, etc.  sysician: To the best on the basis of and manner sta   | of my knowledge, c<br>f examination and/o<br>ated.              | or investigation, in my<br>29c. Licen                                   | opinion, death occur<br>ase number       | red at the time, da                  | te and place, and due d. Date signed (Mont | h, Day, Year)                                      |
| Certification: To Be        | 1 🖫 Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Check only one)   | investigation  6  | building, etc<br>building, etc<br>bysician: To the best<br>bysician: To the basis o  | of my knowledge, c<br>f examination and/o<br>ated.              | or investigation, in my<br>29c. Licen                                   | opinion, death occur                     | red at the time, da                  | ite and place, and due                     | h, Day, Year)                                      |
| Certification: To Be        | 1 MAtural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 one)  29b. Signature and ti  | investigation 6 Could not be determined  1 Certifying Ph 2 Medical Examitite of certifier                                 | building, etc.  sysician: To the best on the basis of and manner sta   | of my knowledge, of examination and/o                           | 29c. Licen D & C  | opinion, death occur<br>ise number       | red at the time, da                  | ite and place, and due                     | h, Day, Year)                                      |
| Medical Certification: To B | 1 SA Atural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 one)  29b. Signature and ti  30. Name and addres  TRUONG B                     | investigation  6 Could not be determined  1 Certifying Ph 2 Medical Examilitie of certifier  ess of person who as AO 1321 | nysician: To the best niner: On the basis of and manner state completed cause of d   | of my knowledge, of examination and/outed.  eath (Item 23a) (Ty | 29c. Licen D & C  | opinion, death occur<br>ase number       | red at the time, da                  | ite and place, and due                     | h, Day, Year)                                      |
| Certification: To Be        | 1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 one)  29b. Signature and ti  30. Name and addres TRUONG B  31. Date filed (Month | investigation  6 Could not be determined  1 Certifying Ph 2 Medical Examilitie of certifier  ess of person who as AO 1321 | nysician: To the best on the pass of and manner state of decompleted cause of decompleted cau | of my knowledge, c<br>f examination and/o<br>led.               | 29c. Licen D & C  | opinion, death occur<br>ise number       | red at the time, da                  | ite and place, and due                     | h, Day, Year)                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rose 6:43 P. April 8, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Frederick Villa Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 🕇 F West Virginia Dec. 1, 1910 Director 217-07-6726 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ☑ No Catonsville Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 1326 Hickory Springs Circle Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Salomone Paul Cascio ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1326 Hickory Springs; Catonsville, MD 21228 Daughter Jean Larkin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition | Cemetery, Crematory of our | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | Comparison | 4/12/2008 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 1901490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes Z No ed by the a Division or Vital Records, P.O. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠No 2 ER/Outpatient 3 DOA P 1 Inpatient this e Hospital or Attending Ph 24 hours after death. e Funeral Director; After th 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year)

Ic? 31. Date filed (Month, Day, Year) 10

29b. Signature and title of certifier

30. Name and address of person who completed

Tibel1

2008

32 Registrar's Signature

cause of death (Item 23a) (Type, Print)

8005

State

Mani

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Not -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 0830AM STEIGHRWALI NATALIE 04 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Levindale Hebrew Geriatric Center Baltimore 8. Date of Birth (Month, Day, Ye March 3, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 1931 Min. 1 M 2 7 Months Days Hours 212 -- 28 - 8691 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2K No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Rollingfield Road Items 23a Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. à Specify: White 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 Is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Harford County Schools Instructional Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Misterka Stanley Konstanty Wozniak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. Nancy S. Stromberg Daughter 200 Rollingfield Road; Catonsville, MD 21228
te of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) nislaus 4/8/2008 | Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke St. Stanislaus 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 727 1 1630 Edmondson Avenue; Catonsville 1901490 MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ERMINAL DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 thknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: P 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) AJAN, BABATUMBE Mu 31. Date filed (Month, Day, Year) APR 1 0 2008

PHYSICIAN

2434 2. Registrar's Signature

29c. License number

D0064533

W. BELVEDERE

29d, Date signed (Month, Dav. Year)

2008

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Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 12:36 PM 2008 Johanna R. Schneider APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 219-18-1801 Yrs 86 8, 1921 Maryland Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examinations be notified at 1 ☐ Yes 2 ☑ No Directo Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 5 Rumford Drive #102 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ⅓Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home othari 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Thomas J. Rohe Mary Elizabeth Stromberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 108 Forge Haven Drive; Perry Hall, MD 21128 pe of Disposition (Name of Date 20c. Location - City or Town, S othar <u>Stephen J. Schneider</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If ö \* 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 4/7/2008 Baltimore, Maryland 21. Signature of Funer Service Lice see Mol290 | 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 any 23a. Pan . Enter the dis shock, or heart fail re.
Immediate Cause (Findisease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Pulmonary hemorrhage **Physician** week /Medical Due to (or as a consequence of): Examiner 10 Inter Stitia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): attending physician for use as the buria Pg lan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 13 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f Physic o. 9☐ Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of cate has l performed? death? certificate Yes 2 🗆 No 2 1 No Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA of this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide ō within 24 hours at To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day, Year) April 3 ,2008 D37359 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selber 900 S. Caton Avenue; Baltimore, MD 21229 31. Date filed (Month, Day, Year)

State

Registrar

APR 1 0 2008

2. Registrar's Signature

|                   |  |                     | 1 - State Amend Item   | State of Market American State of Market 23a per di | aryland              | d / Depa<br>78,04                 | artment of F  | lealth ar<br>Death                            | nd Mental Hy                                    | giene<br>Reg. No.   | 2008  | 1710  |  |  |
|-------------------|--|---------------------|--|---|----------------------|-----------------------------------|---|---|---|---|---|---|--|--|
|                   | Physici  | an                  | 1. Decedent's Name (First, Middle, Las   | t)  |                      |                                   | ACCHE   | TTI   | 2. Date of De Month                             | Day   |   | 3. Time of Death                                |  |  |
|                   | /Medi  | cal                 | JOSEPHIN<br>4a. Facility Name (If not institution, give  | street and number)                                  |                      | 5                                 | ACCHE 4b. City, Town, o                                       |   | MARCH   |   | 7 2008<br>County of Death                                     |   |  |  |
|                   | Examir   | ier                 | JOHNS HOPKIN   |   | IEW                  | /                                 | BALTIM  |   | CITY  |   | N/A   |   |  |  |
|                   | Funeral<br>Director  |                     | 5. Social Security Number 6. Social Security Number 16. Social Security Number 17. Social Security Number 18. Social Security Number 19. Social Security Num | 7. Ag   |                      |                                   |   |   | Hrs. 8. Date of Bi<br>Min. (Month, Da<br>10-07- | 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country) 10-07-1926 New Jel                          |   |   |  |  |
| -                 | within 72 hours after death with the Maryland<br>lene.<br>than "natural", or items 23a or 28a-f show<br>he Mardical Examiner must be notified at |                     | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City            | /. Town or Lo                     | cation  |   |   | 10d. Inside City  |   |   |  |  |
|                   |  | tor                 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |   |                      |                                   |   |   |   |   | 1 ☐ Yes Z\[ No  |   |  |  |
|                   |  | Director            | 10e. Street and Number   | Dane  |                      | 10f. Zip Code                     |   |   | 10g. Citizen of What Country?                   |   |   |   |  |  |
|                   |  |                     | 1703 Bethlehem Ave   |   | 21222                |                                   | Unit  | United States                                 |   |   |   |   |  |  |
|                   |  | by Funeral          | 11. Marital Status  1 □ Never Married  2 ☑ Married  1 □ Never Married  2 ☑ Married  12. Was Decedent E Armed Forces?  1 □ Yes 2 ☑ M If Yes, Give Year or Dates:  |   |                      |                                   | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 🔀 No    | lispanic Origir<br>an, Mexican, f<br>Specify: | n? (Specify Yes or No<br>Puerto Rican, etc.)    | pecify Yes or No-<br>o Rican, etc.) 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White |   |   |  |  |
| -                 |  | Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12 years   |   |                      | (Give<br>life. i                  | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most o<br>d)                           | 16b. Kind of Business/Industry                  |   |   |   |  |  |
|                   |  |                     |  |   |                      | Contra                            | act Speci   |   | Name (Final Adiable                             |   |   | Security Admin                                  |  |  |
|                   | Mental Hyg<br>Mental Hyg<br>arked other<br>atic event,   | Be                  | 17. Father's Name (First, Middle, Last) Gulio Trecannelli  |   |                      |                                   |   |   | Name (First, Middle<br>Mondela                  | e, Maiden   | Surname)  |   |  |  |
|                   | 2 P E  | ပ                   | 19a. Informant's Name/Relationship (7  | ype. Print)   |                      | 19b. Mailir                       | ng Address (Street  | and Number                                    | or Rural Route Numb                             | ber, City o   | r Town, State, Z  | ip Code)  |  |  |
|                   | es lan<br>of Heal<br>item 2  |                     | Rudolph A. Sacchet   | ti (husba   | nd)                  | 1703                              | Bethlehe  | m Aven  | ue Dundall                                      | k, Ma   | ryland  | 21222   |  |  |
| ,                 |  |                     | 20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  |   | Ce                   | emetery, crei<br>                 | sition (Name of<br>matory or other place<br>Faith Cem         |   | Date -31-2008                                   |   | cation - City or  | Town, State  Maryland                           |  |  |
|                   | Department Department Important: If any injury of once.  |                     | 21. Signature of Fuperal Service Licen   | see ,   | Judi                 | Di                                | 2. Name and Addre   | ss of Facility<br>Funera                      | 1 Home of                                       | Dund  | lalk, In  | .C.   |  |  |
|                   | hysician<br>/Medical<br>Examiner   |                     | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Ceuse (Final<br>disease or condition<br>resulting in death)   | only one cause on each line.                        |                      |                                   |   |   |   |   | Approximate Interval Between Onset and Death 36 Novel 2 downs |   |  |  |
|                   | physician and strength is the burial-transit   | edical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last   | a consequence a consequence                         | TOL                  | IC HEA                            | E   | 8 years                                       |   |   |   |   |  |  |
|                   | es that the default certing gned by the attending be detached for use a  |                     |  | d. Conges   | sti <b>v</b> e       | Heart                             | Failure   |   |   |   |   | 2 years   |  |  |
| 1                 |  | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  | e pf pregna<br>2 □ Fetal<br>t time of de            | Ideath 3             | Ectopic pregnancy Other (specify) | 4   | 23d. Date of delivery  Month Day Year         |   |   |   |   |  |  |
| necords, r.o.     |  | by                  | r art ii. Other significant containous containously to death but not resoluting in the underlying value given in Part i.   |   |                      |                                   |   |   |   |   |   | 11  |  |  |
| F                 | ate ha   | Completed           |  |   |                      |                                   |   |   | 24a. Was<br>auto<br>perf<br>1 Yes               |   | prior to c  | topsy findings available completion of cause of |  |  |
| LIVISION OF VICAL | certificate<br>rector, pag   | Be (                | 25. Was case referred to medical examiner?   |   |                      |                                   |   |   |   |   |   |   |  |  |
|                   | this ral dir   | Certification: To I | 1 Yes No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident  |   |                      |                                   |   |   |   |   |   | cify)   |  |  |
|                   | to the nospital or Attending Fri<br>within 24 hours after death.  To the Funeral Director: After th<br>completely filled in by the funeral       |                     | 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date of Injury 28b. Time of Injury 4 Work?  M 1 Yes 2 No  28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred   |   |                      |                                   |   |   |   |   |   |   |  |  |
|                   |  |                     | 4 ☐ Homicide building, etc. (Specify)  City or Town, State)  |   |                      |                                   |   |   |   |   |   |   |  |  |
|                   |  | Medical             | 29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                      |                                   |   |   |   |   |   |   |  |  |
| 4                 | within<br>To the   | Me                  | 29b. Signature and title of certifier  | a' .  |                      |                                   | 29c. Licens   |   |   | 29d. Dat  | e signed (Month   | h, Day, Year)                                   |  |  |
| ,                 | 1  |                     | Michelle   | 4 hunden  | , MEDIC              | CAL DOC                           | TOR RO  | 55-00   | 00  | MAR   | CH 2-   | 1, 2008   |  |  |
| /                 | 1)   |                     | 30. Name and address of person who   |   |                      |                                   |   |   |   |   |   |   |  |  |
| 1                 | $\varphi$  | •                   | MICHELLE ZIKUSOKA, 31. Date filed (Month, Day, Year)   | 4940 <i>EAS</i><br>32 Registr                       | TERN<br>rar's Signat | J AVCN                            | WE, BALTI   | MORE,   | MARYLAN   | VD, 2   | 1224  |   |  |  |
|                   | Sta<br>Registi   |                     | APR 0 8 200  | 8 Kelgue  | , It                 | Local                             |   |   |   |   |   |   |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 8, <sup>Day</sup> 2008 Year **Physician** Michele A. Taylor 2:55 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** September 29, 1951 Min. 1 □ M 2 🛛 F Months Days Hours 56 218-58-4188 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show Examiner must be notified at 1 □Yes 2 No Director North East Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ò 21901 USA 229 Inspiration Road 23a Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛣 No Specify. Specify: White à 3 ☐ Widowed 4 Divorced natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Audrey Hyle Walter R. Taylor Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau 229 Inspiration Road, North East, Maryland Mark McKittrick son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 11, 1 XBurial 2 Cremation 3 Removal from State Dundalk,Maryland Oak Lawn Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the deat // Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform certificate 1 ☐Yes 2 No 1 □ Yes 2 🗀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number **9 68303** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles & Towson MD 4204 HALLES MAD 6701 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13:21 P.M. **Physician** LEROY TOLSON Α. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 KM 2 DE 84 July 18,1923 Maryland Director 215-16-5509 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show notified at 1 XYes 2 No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 120 South Charles Street 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Baltimore Citv permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If Item 27 is marked other the any Injury or other treasment. Maintenance Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jackson Tolson Goldie Gardner 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Weaver Jr. (Nephew) 416 Holy Cross Road, Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Bayview Crematory 04-11-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License /22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Corenery or any Immediate Cause (Final **Physician** ary disease or condition resulting in death) /Medical onsequence Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed as the burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten e detached for u 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 Mo Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bade 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform certificate 2 No 1⊟ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 □ DOA 2 1 Inpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of perti MA

HT

State Registrar 30. Name and a

0 2008

Olen Burnie MD 21032

cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 7:35 a M Osborne Tinsley 4 /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Joseph Richey 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **№** M 2□ F Director 229-38-6372 8-22-1931 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Merical Examiner must be notified at Director N/A Baltimore 1√2 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2634 E. Federal Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1♥ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Service 1 and 2 should be filed w Health and Mental Hygier 3m 27 is marked other th <u>12th grade</u> Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sam Tinsley Mary Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important; if item 27 is
any injury or other trau Shirley Tinsley - Wife 2634 E. Federal Street Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-7-2008 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202 23a. P.in1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lunc **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown signed by ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The lav 24a. Was an cate has autopsy performed Division or Vital Yes 2 No Physiciar: 25. Was case referred to medical 26. Place of Death (Check only one) certi Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NOS PICE 1 Yes 25No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Patter death. 1 Matural 5 Pending investigation Injury 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerai L Hospitai 29a. Certifier (Check only one) Constituting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Osborne

30. Name and address of person who compared cause of death (Item 23a) (Type, Print)

0 2008

32. Registrar's Signature

OK TOOME

State

Registrar

manner stated

2008

who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

29b. Signature and title of certifier

Mary G. Ripple MD.

31. Date filed (Montin

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 31, 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 APRIL Physician TOMPAKOV 6 5:50P ™ SAMUEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 7 SLADE AVENUE, #512 PIKESVILLE if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 03/22/1915 93 220-20-9235 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt: If Item 27 is marked other than "natural", or items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE, #512 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify. Specify. Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS TOMPAKOV ROSE **EXLER** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE SALAMA / DAUGHTER RAISIN TREE CIRCLE, PIKESVILLE, MD 20b. Place of Disposition (Name of Camelary or other place)
CHIZUK AMUNO CONG. 04/09/2008 20a. Method of Disposition Department of Important: If II any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Singure of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zdeys **Physician** heart discie 15 Chemi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician sthe burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? res 2**1** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 🗌 Inpatient Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kuhado Beng, 21) 4/7/08 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Richard A. Seg. 40; Sente 450; 10755 Folls Rd, L. Renville, 4d 21093 22. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 0 2008 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |                            | 1 - For State Registrar   | State of   | Marylar   |   | artment of H   |               |             |                          | iene 20                         | 08  | Wede funds                            | 716        |
|---|--|----------------------------|---|--|---|---|--|---------------|-------------|--------------------------|---------------------------------|---|---------------------------------------|------------|
|   | Dhysiai  | - n                        | 1. Decedent's Name (First, Middle   | e, Last)   |   |   |  |               |             | 2. Date of Deat<br>Month | h<br>Day                        | Year                                      | 3. Time o                             | of Death   |
|   | Physici<br>/Medic  |                            | David E. Upt  |  |   |   |  |               |             | March 26                 |                                 |   | 6:15                                  | AM M       |
|   | Examin   | er                         | 4a. Facility Name (If not institution, give street and number) 7609 Chelton Road  |  |   |   | 4b. City, Town, or Location of Death  Bethesda   |               |             |                          | 4c. County of Death  Montgomery |   |                                       |            |
|   |  |                            | 5. Social Security Numberink  |  | . Age (In yrs.  | last hirthday)  | If Under 1 Year  | If Under:     | 24 Hrs.     | 8. Date of Birth         |                                 |   | ry<br>place (State                    | or Foreign |
|   | Funeral<br>Director  |                            | dik   | 1 <b>∑</b> M 2□F   | 65  | Yrs.  | Months Days  | Hours         | Min.        | Dec 8,                   | 1942                            | Coui                                      | ntry)                                 | unk        |
| 70  | _  | Funeral Director           | Usual Residence of Decedent   |  |   |   |  |               |             |                          |                                 |   |                                       |            |
|   | Department or nearm and wenter hygene.  Department if them 27 is marked other then "naturel", or iteme 23s or 28s-f show eny injury or other traumatic event, the Medical Exacting Instrument be notified at once. |                            | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City   |  |   |   |  |               |             |                          |                                 | City Limits<br>is 2 √ No                  |                                       |            |
|   |  |                            | MD Montgomery Bethese 10e. Street and Number 10f.   |  |   |   |  |               |             |                          |                                 |   | . Citizen of What Country?            |            |
| with  |  | ā                          | 7609 Chelton Road   |  |   |   | 10f. Zip Code  | -             | USA         |                          |                                 |   |                                       |            |
| after deeth   |  | era                        | 11, Marital Status  | 11. Marital Status 12. Was Decedent Ever in                |   |   | Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri  □ Yes 2 No Specify: |               |             | cify Yes or No-          | 14. Race - American Inc         |   |                                       |            |
|   |  |                            | Agmed Forces'  1 ⚠ Never Married 2 ☐ Married 1 戶 Yes, Give  |  |   | - 1   |  |               |             | Rican, etc.)             |                                 | Black, White, etc.  Specify: white        |                                       |            |
| Sours   | E  | d by                       | 3 ☐ Widowed 4 ☐ Divorced  | Year or Da   | tes:  |   | 10 165 220 140   | эрвину.       |             |                          |                                 |   |                                       | -          |
| within 72 h   | nati   | Completed                  | 15. Decedent's Education<br>(Specify only highest grade completed)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) |  |               | t of workir | unk g                    | 16b. Kind of Business/Indus     |   | dustry                                | unk        |
|   | then.  | μŽ                         | Elementary/Secondary (0-12) unk   | College (1-<br>unk   | 4or 5+)   | me. Server ascretined   |  |               |             |                          |                                 |   |                                       |            |
| D = 1   | Hygi<br>other<br>ent, I  | Be Co                      | 17. Father's Name (First, Middle,   |  |   |   | unk  | 18. Mothe     | er's Name   | (First, Middle, M        | Maiden Sumam                    | 10)                                       |                                       | unk        |
| p p   | Aenta<br>rked<br>tic ev  | To B                       |   |  |   |   |  |               |             |                          |                                 |   |                                       |            |
| d 2 sho   | th and h   |                            | 19a. Informant's Name/Relations Montgomery Co   | , , ,,   | t   | 19b. Maili  | ng Address (Street   | and Numbe     | er or Rura  | l Route Number           | City or Town,                   | State, Zip                                | Code)                                 | unk        |
| Pages 1 and   | it of Heal<br>If item 2<br>or other  |                            | 20a. Method of Disposition 1 Burial 2 Cremation   | 3 □Removal from S  |   | Place of Dispo<br>cemetery, crei  | osition (Name of<br>matory or other place  | (e) 1         | D           | ate                      | 20c. Location -                 | City or To                                | own, State                            |            |
| it. Pa  | artmen<br>ortant:<br>injury<br>i.  |                            | 4 Donation 5 Other (S   |  |   | 22  | 2. Name and Addre  | ss of Facilit | tv          |                          |                                 |   |                                       |            |
| permit.   | Depar<br>Impor   |                            | 21. Signatule of Funeral Service Licensee Ronald S. Wade, Sirector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201  |  |   |   |  |               |             |                          |                                 |   |                                       | :          |
| //  | ysician<br>Medical<br>aminer   | ,                          | shook or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | Due to (d  | ch line.  | juence of):   | er the mode of dyin  | ig, such as   | cardiac o   | r respiratory arri       | est,                            | D   | Approxima<br>Interval Be<br>Onset and | etween     |
| UNISION OF VICE TO DO DO DO DO DO DO DO DO DO DO DO DO DO | been signed by the ettending physiclen and should be detached for use as the burial-transit  | Physician/Medical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d  |  |   |   |  |               |             |                          |                                 |   |                                       |            |
|   |  |                            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | 1 ☐Live bir<br>4 ☐ Pregna                                  | 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown |   |  |               |             |                          |                                 | 23d. Date of delivery<br>Month Day Year   |                                       |            |
| ires that   |  | Ď                          |   |  |   |   |  |               |             |                          | oacco use cont                  | cco use contribute to the cause of death? |                                       |            |
| S Section   |  | Completed                  | 24a. Was an   |  |   |   |  |               |             |                          |                                 | 24b. Were autopsy findings available      |                                       |            |
| e la  | 2 0  | ם                          |   |  |   |   |  |               |             | autops                   | y I                             | prior to co<br>death?                     | ompletion of                          | cause of   |
| بة ال <b>عا</b>   | certificete<br>rector, pag   | e Co                       | 25 Was case referred to medica  |  |   |   |  | 00 Dis-       | of Dooth    |                          |                                 | I ☐ Yes                                   | 2□ No                                 |            |
| /sicie  | s cert<br>direct   | 0 8                        | 25. Was case referred to medical examiner?    A yes 2   No  |  |   |   |  |               |             |                          |                                 |   |                                       |            |
| anding Phy  | erthi<br>eral c  | n: T                       | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred   |  |   |   |  |               |             |                          |                                 |   |                                       |            |
|   | within 24 mous after to beam.  To the Funeral Director: After this cardicete he completely filled in by the funeral director, page   | atio                       | 2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 1 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |               |             |                          |                                 |   |                                       |            |
| al or Atte  |  | ertification:              |   |  |   |   |  |               |             |                          |                                 | mber,                                     |                                       |            |
| • Hospita   | 24 hours<br>Eunera<br>letely fille   | edical C                   |   | ng Physician: To the t<br>Examiner: On the bas<br>and many | sis of examina  |   |  |               |             |                          |                                 |   |                                       | n(s)       |
| To th   | To th<br>comp  | Me                         | 29b. Signature and title of certifie  | Bron V   | - ms  | ome   | 29c. Licens  |               | ی در        |                          | 9d. Date signed                 | d (Month,                                 | Day, Year)                            | 2 8        |
|   |  | - 1                        | 30. Name and address of person  | who completed cause  | of death (Iter  |   | Print) 2 /   | 0/            | me          | Local                    | 10                              | Er  | 200                                   | , 0        |
|   |  |                            | IRA NB  |  | mo  | 0 -   | E 5,1  | VPS           |             | pring                    | mo                              | 2   | 1902                                  |            |
|   | Sta  | ite                        | 31. Date filed (Month, Bay Year)  | 108 32. Re   | gistrar's Signa   | ature Annual  | 1/2  |               | V           |                          |                                 |   |                                       |            |

DHMH 17 Rev 1/2001

08-01742 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Underwood State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0051 hrs **Medical Examiner** Anthony Underwood Jr. March 1, 2008 4a. Facility Name (if not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death 5024 Denmore Avenue Apt. 2B **Baltimore** 5. Social Security Number If Linder 1 Year I if Under 24Hrs. 9 Birthplace (State or **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) Foreign Months Days Hours Director 095-62-8551 12 28 78 NY Country) 1 XM 2 29 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No MD N/A Baltimore with the Maryland Director 28a-f 10e, Street and Number notified at 10f. Zip Code 10g. Citizen of What Country? Madison Avenue 1717 W. 21217 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, must be death v 1 XNever Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes 0 after Widowed . Give Yea Divorced Yes 2 X No specify: Specify: Black marked other than "natural", event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "r or other traumatic event, the Medical E MD 21215-0036 N/A Atco Rubber Co. Warehouse Man 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Anthony Underwood Sr. Wilma Hussey 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Hussay-mother 127 Kennedy Circle Rocky Mount, NC 27801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State Baltimore MD tment o Zion Cem. 3/7/2008 Mt. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of Other (Specify) 5 ned by the atte detached for u 1 Yes 2 No 9 Unknown death Unknown g P.0. signed by 1 be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 V Unknown Records, Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 s death? 1 🗸 Yes Yes 2 No 2 Nο 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital director, Be examiner? Hospital: Other<sub>4</sub> Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this 1 Yes funeral 28a. Date of Injury (Month, Day, Year) Mar 1, 2008 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot Natural 0047 hrs Yes 2 ✔ No Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 5024 Denmore Avenue Apt. 2B, Baltimore, MD determined 4 V Homicide (Specify) Multi-Family Apt.

Hospital or Attending Physician: 24 hours after death. Funeral Director: filled in by completely To the 1

> Theodore M. King, Jr., MD. 31. Date filed (Mo. State 2008 Registrar

29b. Signature and title of certifier

29a. Certifier

ca

Assistant Medical Examiner 32 Registrar's Signature 2 16 10 -1

and manner stated

Name and address of person who complete cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

DOME

29d. Date signed (Month, Day, Year)

March 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04 12:04 Valencia 03 thna /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** Maryland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 KF PA Director 199-07-9534 Dec 31, 1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No **Funeral Director** Harrisburg PA Dauphin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17112 U.S.A 7717 Althea Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian or items 11 Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 □ Yes 🐼 No 3altimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16b Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental H Samuel Rusnov Anna Rusnov မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1340 Woodbridge Dr. Middletown, PA 17057 Marcia Breinch 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. Burial 2 □Cremation 3 □Removal from State Apr 07, 2008 Oberlin, PA 4 Donation 5 Dother (Specify) Churchville Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the dile se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** 5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autope performed: 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 V No 2008 2055 PM Accident death. Director: 6 ☐ Could not be 3 ☐ Suicide lace of injury - At home, farm, street, factory, office building, etc. (Specify) Rural Route Number, Location (Street and Number or City or Town, State) after 4 Homicide 10771 Terrace within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore, MD 2120 22 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** J.H. VOGEL FLMER 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Good Samariku Baltimore HOS PITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/04/1916 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1**X** M 2□ F 91 Director 215-09-1914 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10b. County 1 X Yes 2 No Funeral Director MD N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be 1 any injury or other traumatic event, the Medical Examiner must be 1 21206 4307 Willshire Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Caterer Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wilford Vogel Martha Bender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan D. Vogel, Son 716 Burnside Drive, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemtery 4 Donation 5 Other (Specify) 04/12/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Conducall 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYO CARDIA resulting in death) /Medical Due to (or as a consequence of): ngeslive Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Aorlic sician and burial-tran Due to (or as a consequence of): Physician/Medical attending physic I for use as the b 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 4 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ☐ Accident Director: 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours a

State

31. Date filed (Month, Day, Year) 1 0 Registrar

Anila

(Check only

29b. Signature and title of certifier

ler

KAW

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

5601 -och 32. Begistrar's Signature

ORIGINAL

29c. License number

KES-

000

29d. Date signed (Month, Day, Year)

Blud : Baltimor, Mo

DHMH 17 Rev 1/2001

| Physician |
|-----------|
| /Medical  |
| Examiner  |

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitet or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| Registrar amend #210   | 22 rei mia   | DD GGE                       | runcate of  | Dealli                              |   | Reg. No.    |   |  |
|--|--|------------------------------|---|-------------------------------------|---|-------------|---|--|
| 1. Decedent's Name (First, Middle, Last)   | ritler   |                              |   |                                     | 2. Date of De                               | 20          | e Ö8  | 3. Time of Death   |
| 4a. Facility Name (If not Institution, give s Anchorage Nurs   | ing & Rehold   | Center                       | Sali  | Sbury                               | 1   | U           | County of Death                                 | ico  |
| 210-30-1327  | M 2⊠F 74   | yrs. last birthday)<br>Yrs.  | Months Day  |                                     | Min. 8. Date of Bi<br>(Month. Di<br>4/12/1  | 933         | nplace (State or Foreign<br>untry)<br>"yland    |  |
| Usual Residence of Decedent  | 1.5  |                              |   |                                     |   |             |   | 40.11.11.00.11.00  |
| 10a. State 10b. County  Maryland Wicomico  |  | . City, Town or Lo<br>Salisi |   |                                     |   |             |   | 10d. Inside City Limits 1X Yes 2 ☐ No                        |
| 10e. Street and Number   |  |                              | 10f. Zip Code   |                                     |   | 10g. Citi   | izen of What Co                                 | untry?   |
| 105 Times Square   |  |                              | 218   |                                     |   |             | JSA   | does ladica  |
| 11. Marital Status   | 2. Was Decedent Ever<br>Armed Forces?  | in U.S. 13.                  | Was Decedent of   | Hispanic Origin<br>Iban, Mexican, F | ? (Specify Yes or No<br>Puerto Rican, etc.) | o-          | <ol> <li>Race - Ame<br/>Black, White</li> </ol> |  |
| Maryland Wicomico  10e. Street and Number  105 Times Square  11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  Thomas James Harr | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                             |                              | 1 ☐ Yes 2 🗷 N   |                                     |   |             | Specify: W                                      | hite   |
| 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)  | (Give                        | dent's Usual Occ<br>kind of work don<br>DO NOT use reti | e durina most o                     | f working                                   | 16b. Ki     | ind of Business/                                | Industry   |
| Elementary/Secondary (0-12)  | College (1-4or 5+)   | wait                         |   |                                     |   | fc          | ood serv  | ice  |
| 17. Father's Name (First, Middle, Last)  |  |                              |   | 18. Mother's                        | Name (First, Middle                         | , Maiden    | Sumame)   |  |
| Thomas James Harr  | ington   |                              |   | Made                                | elyn (ı                                     | ınkno       | own)  |  |
| 19a. Informant's Name/Relationship (Type<br>Michael E. Whitle  | ·  |                              | •   |                                     | or Rural Route Numb                         |             |   |  |
| 20a. Method of Disposition 1 ☐ Burial 2 【文 Cremation 3 ☐ R   | emoval from State  | -                            | matory or other p                                       | 1                                   | Date  |             | ocation - City or                               |  |
| 4 □Donation 5 □Other (Specify)   |  | Salisbur                     |   |                                     | /1/08                                       |             | sbury,  | MD   |
| 21. Signature of Funeral Service License   | Ronald S.  | Wade,                        | ANTIOWAY<br>501 Snow                                    | rest of Facility                    | State And                                   | resa        | y Board<br>MD 218                               | <del>sseciatie</del> n<br><del>04</del>                      |
| 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  | e cause on each line.  | arcin                        |   | 0 -                                 | ra Stract.<br>Locleni                       |             | Lto,MD  | 2 Approximate<br>Interval Between<br>Onset and Death         |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a cor  |                              |   |                                     |   |             |   |  |
| 23b. Was decedent pregnant   | 3c. If yes, outcome of pro- 1 Live birth 2 L 4 Pregnant at time 9 Unknown    | Fetal death 3                | □Ectopic pregnar<br>□ Other (specify)                   |                                     |   |             | 23d. Date of del<br>Month                       | ivery<br>Day Year  |
| Part II. Other significant conditions con  | tributing to death but no  | t resulting in the           | underlying cause  | given in Part I                     | 23e. Did                                    | tobacco i   | use contribute to                               | the cause of death?  |
| - artii. Ottor oigon   | induing to dodin but no  |                              | andonying sadso   | giv av ii. v ait i.                 | 1   | Yes 2       |   | _/   |
| in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con   |  |                              |   |                                     | 24a. Waa<br>auto<br>peri<br>1 □ Yes         |             | prior to death?                                 | atopsy findings available<br>completion of cause of<br>2□ No |
| 25. Was case referred to medical   |  |                              |   | 26. Plaçe o                         | f Death (Check only                         | one)        |   |  |
| examiner? 1 Yes 2 No   |  | 2 ER/Outpatie                | nt 3 DOA  | Other: 4 Nurs                       | ing Home 5 ☐ Res                            | idence      |   | cify)  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Yea                                       | 28b. Time (<br>ar) Injury    | V   | juryat<br>/ork?<br>□Yes 2□No        | 28d. Describe                               | how inju    | ry occurred .                                   |  |
| 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury -<br>building, etc. (Sp                                 | At home, farm, si            | treet, factory, offic                                   | ea ·                                |   | (Street and |   | ural Route Number,   |
|  | sician: To the best of my<br>ner: On the basis of examination manner stated. |                              |   |                                     |   |             |   |  |
| 29b. Signature and title of certifier  |  | -                            | 29c. Lice   | nse number                          |   | 29d. Da     | ite signed (Mont                                | h, Dav. Year)  |
| N 1 A  | M Lon  | D                            |   | 00639                               | 91  |             | -1-20   | -  |
| 30. Name and address of pers in who co   | mpleted cause of death   | (Item 23a) (Type             | Print)  | N St. S                             | SUITEB,                                     | SAL         | ISBUR'  | 4, MD.   |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 0 2008

**ORIGINAL** 

32. Registrar's Signature

|                     |  |                | Sta<br>For State<br>Registrar   | ite of Maryland   |                             | rtment of H  |               | nd Mental Hy                                       | giene<br>Reg. No.              | 08  | 11721  |
|---------------------|--|----------------|---|---|-----------------------------|--|---------------|--|--------------------------------|---|--|
|                     | Physici  | an             | 1. Decedent's Name (First, Middle, Last)  | Ali Des. A  | ki`                         |  |               | 2. Date of Domestin                                | aath Day                       | Year  | 3. Time of Death                                   |
|                     | /Medic   |                | 4a. Facility Name (If not institution, give street  | and number)   |                             | 4b. City, Town, or   | r Location of |  | 4c. Count                      | ty of Death   |  |
|                     |  |                | 5. Social Security Number 6. Sex  | 7. Age (In yrs. las   | 4                           | Baltimo  |               | Hrs. 8. Date of B                                  | rth                            | O. Riethe   | place (State or Foreign                            |
|                     | Funeral<br>Director  |                | 5. Sócial Security Number 6. Sex 1 M 2  |   | Yrs.                        | Months Days  | Hours         | Min. (Month, D                                     | ay, Year)                      | Mary.   | ntrv)  |
|                     | pue *  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c, City. 7  | Town or Lo                  | cation   |               |  |                                |   | 10d. Inside City Limits                            |
|                     | Maryli<br>-f eho   | tor            | MD  |   | altim                       |  |               |  |                                |   | 1. Yes 2 □ No                                      |
|                     | or 288   | Director       | 10e. Street and Number  |   |                             | 10f. Zip Code  |               |  | 10g. Citizen of                |   | ntry?  |
|                     | eath w   |                | 2095 Rockrose Avent   | as Decedent Ever in U.S.  | 13 \                        | 212  |               | n? (Specify Yes or N                               | US                             | SA<br>ace - Americ  | can Indian.  |
| 920                 | 72 hours after death with the Maryland<br>Insturat; or ttema 23e or 28e-f ehow<br>diest Enaminer must be nutified at | by Funeral     | 1 Never Married 2 Married 1 (   | med Forces?<br>□Yes 2[X]No<br>/es, Give<br>aar or Dates:                      | l li                        | Yes, specify Cuba  | Specify:      | Puerto Rican, etc.)                                | Bla                            | ack, White,<br>ify: whi                                     | etc.   |
| Maryland 21215-0036 | 드 '글 왕   | Completed      |   | oleted)<br>illege (1-4or 5+)  | (Give<br>life. L            | ent's Usual Occup<br>kind of work done<br>OO NOT use retired | during most o | of working   | 16b. Kind of 8                 |   | ·  |
| d 2                 | filed with<br>Hygiene<br>othar thai  |                | 17. Father's Name (First, Middle, Last)   | 0   | sear                        | nstress_   | 18. Mother's  | s Name (First, Middle                              |                                | othing  | g  |
| /lan                | 2 should be and Mental is marked c   | То Ве          | John Wirth  | _   |                             |  |               | Kanary   |                                |   |  |
| Man                 | 12 sho<br>h and<br>7 is ma<br>trauma   | 9              | 19a. Informant's Name/Relationship (Type, Pr<br>John Wilinski/son   | int)  |                             |  |               | or Rural Route Numi<br>Ltimore, M                  |                                | n, State, Zip   | o Code)  |
| Baltimore,          |  |                | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remov.  '4 ☒ Donation 5 □ Offien (Specify)         | cem   | e of Dispo                  | sition (Name of<br>natory or other place                     | 1             | Date   | 20c. Location                  | - City or To  | own, State   |
| Baltii              | permit. Page<br>Department (<br>Important: If<br>any injury or<br>once.  |                | 21. Signature   Suneral Service Licensee  | Director  |                             | Name and Addre<br>ate Anat<br>ltimore,                       | _             | ard 655 W<br>1201                                  | . Baltin                       | nore S  | Street   |
|                     |  |                | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau                  | s that caused the death.<br>se on each line.                                  | Do not ente                 | er the mode of dyin  | g, such as ca | ardiac or respiratory                              | _                              |   | Approximate<br>Interval Between<br>Onset and Death |
|                     | Pnysician<br>/Medical  | 4              | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a conseque  |                             | ic Car   | dich          | Societa  | Disos                          | ا عا  |  |
| В                   | Examiner   |                |   | Due to (or as a consequen   | nce or).                    |  |               |  |                                |   |  |
|                     | ed sit   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque  | nce of):                    |  |               |  |                                |   |  |
| Ć                   | rate be executed<br>hysician and<br>the burial-transit   | Examine        | that initiated events c   | Due to (or as a conseque  | nce of):                    |  |               |  |                                |   |  |
| 8760,               | ate be<br>hysicia<br>the bui   | dicai          | d   |   |                             |  |               |  |                                |   |  |
| Box 6               | death certific<br>e attending pl<br>e for use as t   | hysician/Me    | in the past 12 months?  | yes, outcome of pregnanc<br>Live birth 2 Fetal do<br>Pregnant at time of deal | eath 3                      | Ectopic pregnancy Other (specify)                            | ,             |  |                                | ate of deliver  | rery<br>Day Year                                   |
| P.0                 | that the de<br>led by the a<br>detached t  | ۵.             | 9 ☐ Unknown  Part II. Other significant conditions contribut.   | Unknown   | ing in the ur               | derlying cause giv   | en in Part I  | 23e Did  | tobacco use co                 | ntribute to t   | the cause of death?                                |
| rds,                | es<br>be   | d by           | Tartii. Otto: digiiiioani odiiaidii odiiiioani  |   |                             | ladifying databas giv  |               |  | Yes 2□No                       | 3 🗆 Prot  | 1  |
| Vital Record        | The law<br>e has b<br>age 2 s  | ompleted       |   |   |                             |  |               | 24a. Wa<br>aut<br>per<br>1 \( \text{Yes}           | s an 24b<br>opsy<br>ormed?     | were auto<br>prior to co<br>death?<br>1 \(\sum \text{Yes}\) | opsy findings available ompletion of cause of      |
| /ital               | sician: T<br>certificat<br>rector, p   | BeC            | 25. Was case referred to medical examiner?  | NI.   |                             | 04   |               | of Death (Check only                               |                                |   |  |
| of\                 | hys<br>his   | . To           | 1 ☐ Yes 2 No Hospita<br>27. Manner of Death 28a   | 1 Inpatient 2 E   | NOutpatien  8b. Time of     | 28c. Injur   | y at          | sing Home 5 Res                                    | how injury occu                |   | ify)   |
| ion                 | Attanding or death. ector: After by the fune   | atior          | 2 Accident investigation  | (Month, Day Year)   | Injury                      | Wor  | k?<br>Yes 2∐N | o  |                                |   |  |
| Division            | 7 2 2 2  | Certification: | 3 Suicide 6 Could not be determined 280   | <ul> <li>Place of Injury - At hom<br/>building, etc. (Specify)</li> </ul>     | e, farm, str                | eet, factory, office   |               |  | (Street and Nun<br>own, State) | nber or Rura  | al Route Number,                                   |
|                     | To the Hospital of within 24 hours af To tha Funaral D completely filled in  | edical         |   | To the best of my knowled to the basis of examination of manner stated.       | edge, death<br>n and/or inv | restigation, in my o   | pinion, death | place, and due to the control occurred at the time | , date and place               | e, and due t  | to the cause(s)                                    |
| )                   | To the within 2 To the complex   | Σ              | 29b. Signature and title of certifier   | 2 m   | り                           | 29c. Licens  | 7 C           | 20   | 29d. Date sign                 | led (Month,   | , Day, Year)                                       |
|                     |  |                | 30. Name and address of person who complet  | ed cause of death (Item 2   | За) (Туре,                  | Print)<br>(D. E. Ho  | W) a          | A Cont.  | himore                         | mi  | 21201  |
|                     | Sta<br>Registi   | 100            | 31. Date filed (Month, Day, Year)  APR 1 0 2008   | 32 Registrar's Signatur   | re do                       | ents.  |               | Ji Jack  | 111016                         | 7-1-1-5   |  |

|  |                 |                  | 1 - State of Maryland / E  | •                    | rtment of H                                |                             | d Mental H                               | lygien<br>Reg. No             | 2008                                 | 11722  |
|--|-----------------|------------------|--|----------------------|--|-----------------------------|--|-------------------------------|--------------------------------------|--|
|  |                 |                  | 1. Decedent's Name (First, Middle, Last)   |                      | 74   |                             | 2. Date of Month                         |                               |                                      | 3. Time of Death                                 |
|  | ysicia<br>Vedic |                  | FRANK W6SS6/GV   |                      |  |                             | MARC                                     |                               |                                      | 9:50 AM M  |
|  | amin            |                  | 4a. Facility Name (If not institution, give street and number)   |                      | 4b. City, Town, or                         |                             | Death                                    |                               | c. County of Dear                    |  |
|  |                 |                  | Hospice of Queen Anne  | (ff )                | Stevensv<br>If Under 1 Year                | rille                       | Hrs   0 Date of                          |                               | ueen An                              | ne<br>thplace (State or Foreign                  |
| Fun<br>Dire  | eral            |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last bir  | rnaay)<br>Yrs.       | Months Days                                |                             | Hrs. 8. Date of (Month,                  | Day, Year                     | )   Co                               | York   |
|  |                 |                  | Usual Residence of Decedent  |                      |  |                             | 1/1/1/7                                  | _!/                           | 100 110                              |  |
| rylan  | at              | _                | 10a. State 10b. County 10c. City, Town   |                      | 1.7  |                             |  |                               |                                      | 10d. Inside City Limits                          |
| e Ma<br>8a-f s   | tiffec          | Scto             | MO QUEEN ANNES StevE   | NS                   | V:116                                      |                             |  |                               |                                      | 1 ☐ Yes 2 ☐ No                                   |
| vith th  | pe no           |                  | 10e. Street and Number 531 TAI bot ROAD  |                      | 10f. Zip Code                              | 6                           |  |                               | itizen of What Co                    | ountry?  |
| eath v   | must            | Funeral Director | 11. Mar/tal Status 12. Was Decedent Ever in U.S.   | 13 \                 | Vas Decedent of Hi                         |                             | ? (Snecify Yes or                        | No-                           | 14. Race - Ame                       | erican Indian.                                   |
| fter d<br>riten  | iner            | Fun              | Armed Forces?  1 □ Never Married 2 □ Married 1 1 Yes 2 □ No  | ŀ                    | f Yes, specify Cuba                        | ın, Mexican, P              | uerto Rican, etc.)                       |                               | Black, White                         | e, etc.  |
| ours a   | Exa             | by               | 3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: \$\forall 44-46\$   | 1                    | □Yes 2XINo                                 | Specify:                    |  |                               | Specify: wh                          | iite   |
| 72 hc  | die al          | etec             | 15. Decedent's Education 16a. (Specify only highest grade completed)   | (Give                | lent's Usual Occupa<br>kind of work done o | during most of              | working                                  | 16b. l                        | Kind of Business                     | Industry unk                                     |
| vithin<br>sne.   | a Ma            | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)   |                      | OO NOT use retired                         | ()                          |  | İ                             |                                      |  |
| filed A<br>Hygid   | aut, #          | e Co             | 12 U I   | laci                 | ninist                                     | 18. Mother's                | Name (First, Mide                        | dle, Maide                    | n Surname)                           | -  |
| If yearly A I A I 3-0000  should be filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show   | ic eve          | To B             | Michael Wessely  |                      |  | France                      | es Butala                                | a                             |                                      |  |
| shou<br>and N  | umat            |                  | 19a. Informant's Name/Relationship (Type. Print) 19b   | Mailin               | g Address (Street a                        | and Number o                | or Rural Route Nu                        | mber, City                    | or Town, State,                      | Zip Code)  |
| and 2 salth a salth a 27 is  | er tra          |                  |  |                      | Fox Hill                                   |                             | Ellicot                                  | : Cit                         | y, MD 2                              | 21042  |
| Pages 1 and nent of Health int: If item 27   | or oth          |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State   | Dispo<br>y, cren     | sition (Name of<br>natory or other plac    | e)                          | Date                                     | 20c. l                        | Location - City or                   | Town, State                                      |
| . Pag<br>tment<br>tant:  | jury            |                  | 4 ☑ Donation 5 ☐ Other (Specify)   | ,                    |  | 1                           | ,  |                               |                                      |  |
| portinically, interpretable 2 12 13 10000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show | any in          |                  | 21. Signature of Funeral Service Licensee Ronald S. Made Director  |                      | Name and Address<br>ate Anato<br>1timore,  |                             | ard 655 W                                | . Ba                          | 1timore                              | Street   |
|  |                 |                  | 23a. 111. Enter the discase, or complications that caused the death. Do  |                      |  |                             |  | y arrest,                     |                                      | Approximate<br>Interval Between                  |
| Physic   | cían            |                  | shock, or heart failure. List only one cause on each line.   | Pas                  | 0.0000                                     | Catal                       | 201                                      |                               |                                      | Onset and Death                                  |
| /Med   | _               |                  | disease or condition resulting in death)  a. Due to (or as a consequence   | of):                 | ONORIC                                     | Chiv                        | e ic                                     |                               |                                      |  |
| Exami  | iner            |                  | Sequentially list conditions b. L. V. 6 M. M. A.   | 11                   | 515  |                             |  |                               |                                      |  |
| Pe   | ±i.             | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | of):                 |  |                             |  |                               |                                      | 1,74   |
| xecute   | -trans          | xam              | Cause (Disease or injury that initiated events resulting in death) Last C  | of\·                 |  |                             |  |                               |                                      | -  |
| cate be executed physician and   | buria           | ם                | 200 10 (01 00 0 001004001100   | .,.                  |  |                             |  |                               |                                      |  |
|  | s the           | edical           | 3 d  |                      |  |                             |  |                               |                                      |  |
| leath certific   | nse a           | sician/Me        | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  |                      | 3  |                             |  |                               | 23d. Date of de                      | livery   |
| death  | ed for          | icla             | in the past 12 months?  1 Dives: 2 DNo.  4 Pregnant at time of death   |                      | Ectopic pregnancy Other (specify)          | у                           |  | _                             | Month                                | Day Year   |
| at the   | tache           | Phys             | 9 Unknown  |                      |  |                             |  |                               |                                      |  |
| uires that the de  | pe de           | by               | Part II. Other significant conditions contributing to death but not resulting in   | the ur               | nderlying cause give                       | en in Part I.               |  |                               |                                      | o the cause of death?                            |
| w require  | plnor           | Completed        | WIONEY NOTERS PISONS   |                      |  |                             | -   '                                    | ∐ Yes '                       |                                      | robably 4 Unknown                                |
| e faw  | N               | nple             |  |                      |  |                             |  | las an<br>utopsy<br>erformed? | prior to                             | utopsy findings available completion of cause of |
| n: Th<br>ficate  | r, pag          |                  |  |                      |  |                             | 1 □ Ye                                   | s 2 N                         |                                      | s 2 No   |
| ding Physician: The h. After this certificate ha   | irecto          | Be c             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou   |                      | Othe                                       | or:                         | Death (Check on                          |                               | 0.000                                |  |
| arthis   | erald           | 2                | 27. Manner of Death 28a. Date of Injury 28b.   | Time of              | 28c. Injur                                 | y at                        | ing Home 5 A R<br>28d. Descri            |                               | ury occurred                         | эсіту)   |
| nding<br>it. After   | e fun           | atio             | 1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation  | njury                | M 1 □                                      | k?<br>Yes 2 □No             |  |                               |                                      |  |
| r Atte   | by th           | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa bullding, etc. (Specify)  | rm, str              | eet, factory, office                       |                             | 28f. Locatio                             | n (Street a<br>Town, Sta      | and Number or F                      | ural Route Number,                               |
| ital of a saft   | led in          | Cer              |  |                      |  |                             |  |                               |                                      |  |
| To the Hospital or Attending Physician: The law requires that the death certifulnes thours after death.  To the Funeral Director; After this certificate has been signed by the attending  | letely fil      | Medical          | 29a. Certifier (Check only one)  Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated. | e, deatl<br>id/or in | n occurred at the tirvestigation, in my o  | me, date and ppinion, death | place, and due to<br>occurred at the tir | the cause<br>ne, date a       | (s) and manner a<br>nd place, and du | s stated.<br>e to the cause(s)                   |
| To the   | comp            | Me               | 29b. Signature/and title of pertifier  |                      | 29c. License                               | e number                    |  | 29d. D                        | ate signed (Mon                      | th, Day, Year)                                   |
|  |                 |                  | Hallty Wilkerson)  |                      | 02   | 705                         | 5  | 14                            | 1/3/08                               | . 1  |
|  |                 |                  | 30. Name and address of person who completed cause of death (Item 23a)   | (Type,               | Print)                                     |                             | NORBA                                    | 1                             | GRASON                               | ONY, DILIVU                                      |
|  |                 |                  | 4064 M. WIKERSON, M.D.   | 20                   | 4 M6DIC                                    | A/ (6.                      | NIGARA                                   | NB                            | 2-                                   | 1638   |
| Re   | Stat<br>gistra  |                  | 31. Date filed (Month, Day, Year) APR 10 2008  32 Registrar's Signature  | Sp                   | arke                                       |                             |  |                               |                                      |  |

|  | •  | For<br>State<br>Registrar  | State o   | f Marylan  |   |  | of Healt<br>of Dea                                |               | /lental H   | ygiene<br>Reg. No | 0.0              | nα                          |                        | 1723                        |
|--|--|--|---|--|---|--|---|---------------|---|-------------------|------------------|-----------------------------|------------------------|-----------------------------|
| Physician<br>/Medical  | -  | 1. Decedent's Name (First, Middle,   | Last)   |  | W   | Right  | T   |               | 2. Date of D<br>Month                               | eath<br>Da        | Day Year         |                             | e of Death             |                             |
| Examiner   | J  | 4a. Facility Name (If not institution, THE JOHNS HOPK  | LINS HOS  | PITAL  | In a blindle along  |  | Town, or Locat                                    |               | ,   | 40                | County           | of Death                    |                        |                             |
| Funeral<br>Director  |  | 410-04-9422  Usual Residence of Decedent   | 5. Sex<br>1 □ M 2 💢 F                               | 7. Age (In yrs. 51                                   | Yrs.  | Months   | Days Hou  |               | 8. Date of E<br>(Month, I<br>Sept 1                 | <i>Day, Year)</i> | 956              | 9. Birthpi<br>Count<br>Flor | ry) _ `                | te or Foreign               |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | - 1  | 10a. State         10b. County           MD         Balt           10e. Street and Number  | imore   |  | altimo  |  | Codo  |               |   | 100 0             | izon of M        | 10<br>What Count            | 1 🗆 `                  | e City Limits               |
| ifter death with the Mar<br>r items 23a or 28a-f sl<br>niner must be notified<br>Funeral Director  | leiai D  | 4400 hooper Ave  | 12. Was Dece  | edent Ever in U                                      | .S. 13.   |  | 2122  |               | ecify Yes or N                                      | τ                 | JSA<br>14. Race  | e - America                 | American Indian,       |                             |
| ural", or ite  | n by ru  | 1 ☐ Never Married 2 ☑ Marrie<br>3 ☐ Widowed 4 ☐ Divorced   | d 1 ☐ Yes<br>If Yes, Giv<br>Year or D               | 2 <b>∑</b> No<br>∕e                                  | <ul> <li>I3. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ☑ No Specify:</li> </ul> |  |   |               |   |                   |                  | k, White, e<br>whi          |                        |                             |
| ed within 72 hours a Ygiene. Ter than "natural", oft, the Medical Exant, the Medical Exant   | andino   | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12  | Education<br>grade completed)  College (1           | -4or 5+)   | (Give   | edent's Usual<br>e kind of work<br>DO NOT use<br>eceptic | done during<br>retired)                           | most of work  | ing   | 16b. K            | ind of Bu        | siness/Ind                  | ustry                  | unk                         |
| nould be file Mental Hy narked othe natic event,   | מ  | 17. Father's Name (First, Middle, L. Robert Lewis Jo   | ordan   |  | 1   |  | M   | iary E        | e (First, Middi<br>lectra                           | Ann               | Desi             | ardir                       |                        |                             |
| s 1 and 2 st<br>f Health and<br>Item 27 Is n<br>other traun  | -  | 19a. Informant's Name/Relationshi Johns Hopkins F  20a. Method of Disposition  |   |  | 600<br>Place of Dispo   | Wolfe  | Street  | Balt:         | imore,  | MD                | 2128             | _ `                         |                        | •                           |
| mit. Pages<br>partment or<br>portant: If I<br>y Injury or<br>ce.   |  | 1 Burial 2 Cremation 3 4 Donation 5 Other (Sp. 21. Sign fure of Ronal 1  | ecify)  | State (1)  | cemetery, cre   | _  |   | acility a r d | 655 W   | . Ra1             | timo             | re Si                       | ree                    | t                           |
| Physician<br>/Medical<br>Examiner  | 1  | 23a. Part 1. Enter the disease, or c<br>shock, or heart failure. List o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)           | a. Due to (   | ach line. Ti or GA or as a conseq                    | h. Do not en  | ter the mode   |   |               |   | arrest,           |                  |                             | Onset a                | mate<br>Between<br>nd Death |
| cate be executed physician and the burial-transit dical Examiner   | í  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (  | TRICTIV<br>or as a consequence                       | uence of):  E CARDIONYO PATHY  uence of):  Y VENOUS OCCLUSIVE DISEASE   |  |   |               |   |                   |                  |                             |                        | EARS<br>EARS                |
| attending<br>for use as  | >  -   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown  | 1 ☐Live b   | come pf pregna<br>pirth 2 ∐Feta<br>lant at time of d | I death 3   | ⊒Ectopic pre<br>⊒ Other <i>(sp</i> e                     |   |               |   |                   | 23d. Date<br>Moi | e of deliver                | y<br>Day               | Year                        |
| w requires that the d<br>been signed by the<br>should be detached  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use |  |   |  |   |  |   |               |   |                   |                  |                             | of death?<br>□Unknown  |                             |
| ician: The law requi<br>certificate has been s<br>rector, page 2 should<br>Be Completed  |  |  |   |  |   |  |   |               |   | opsy<br>formed?   | p                | rior to com<br>leath?       | sy findir<br>pletion o | gs available<br>of cause of |
| ul or Attending Physician: after death. I Director: After this certificd in by the funeral director, ertification: To Be (   |  | 25. Was case referred to medical examiner?  1 □ Yes 2 ▼ No  27. Manner of Death  1 ▼ Natural 5 □ Pending investiga   | 28a. Date (Mont                                     |  | ER/Outpatier<br>28b. Time o<br>Injury   |  | Other:  | Nursing Ho    | h <i>(Check only</i><br>me 5 ☐ Res<br>28d. Describe | sidence           |                  |                             | )                      |                             |
| oltal or Attending F<br>urs after death.<br>aral Director: After<br>illed in by the funeral<br>Certification:  |  | 3 Suicide 6 Could no determin  | ed 28e. Place<br>buildii                            | of injury - At hong, etc. (Specify                   | y)<br>  |  |   |               |   | òwn, State        | e)<br>           |                             |                        | lumber,                     |
| To the Hospital of within 24 hours af within 24 hours af To the Funeral D completely filled in Medical Cel   |  | 29a. Certifier (Check only one)  1 ☑ Certifying 2 ☐ Medical Example and title of certifier   | Physician: To the<br>xaminer: On the ba<br>and mann | asis of examina                                      | wiedge, deat<br>tion and/or in  | vestigation,   | t the time, dat<br>in my opinion,<br>License numb | death occur   | and due to the                                      | e, date an        | d place, a       | and due to                  | the caus               |                             |
| F 3 F 0  |  | 30. Name and address of person w   | 1 23a) (Tupe  | RES-000  |   |  |   |               | APRIL 4, 2008                                       |                   |                  |                             |                        |                             |
| State<br>Registrar   |  | OMER NASIR<br>31. Date filed (Month, Day, Year)  |   | HORTH Pegistrar's Signa                              |   |  | BAI   | Timo          | RE, N   | 1ARY              | LAN              | D ·                         | 2   2                  | 84                          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Kenneth L. Wood /Medical 12:45 29 2008 4c. County of Death March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Nursing & Rehab Berlin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan 31, 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 79 Director 408-34-6700 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at be notified Director 1 □Yes 2√ No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ច់ 829 White Oaks Lane 21851 USA or items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 20 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white Specify þ 3X Widowed 4 □ Divorced "natural" Completed Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) broadcaster entertainment h and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berlin Nursing & Rehab 9715 Healthway Drive Berlin, MD 21811 permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5-100ther (Specify) in state 21. Signature of Funeral Servi S. Wade, Director 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part . Enter the dise se, or shoo or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reevs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and is the burial-tran Due to (or as a consequence of): as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Year Day 5 Other (specify) 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 has Certification: To Be

that the death certificate be executed Box 68760, o ۵ Division or Vital Records, Physiclan:

Hospital or Attending

death with the Maryland

72 hours after

Wood Kenneth L ■ Baltimore, Maryland 21215-0036

this After thi after death.

I Director: A in by the fu within 24 hours a

|  |   |  |   | K  |   |  |  |  |  |
|--|---|--|---|--|---|--|--|--|--|
| 10.00  |   | -  |   | 24a. Was an autopsy performed? 1  Yes                          | 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No |  |  |  |  |
| 25. Was case referred to medical examiner?   |   |  | f Death Check onl one                                   | Check onl one  |   |  |  |  |  |
| 1 Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient 3                                | ing Home 5 ☐ Residence                                  | ome 5 Residence 6 Other (Specify)                              |   |  |  |  |  |
| 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   |   | 28b. Time of<br>Injury<br>M                    | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No               | 28d. Describe how injur  |   |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined   | 28e. Place of injury - At h<br>building, etc. (Speci                            | ome, farm, street, fac                         | 28f. Location (Street ar<br>City or Town, State         | nd Number or Rural Route Number,                               |   |  |  |  |  |
| 29a. Certifier (Check only one) Certifying Phase Certifyi | nysician: To the best of my knowniner: On the basis of examinand manner stated. | owledge, death occur<br>ation and/or investiga | red at the time, date and<br>tion, in my opinion, death | place, and due to the cause(s<br>occurred at the time, date an | ) and manner as stated.<br>d place, and due to the cause(s)                                 |  |  |  |  |

| 29b. Signature and title of confifer |    |
|--------------------------------------|----|
| 11/19/                               | 1  |
| 1110 min                             | -L |
|                                      |    |

31. Date filed (Month, Day, Year)

APR

Registrar's Signature

Coashal Hadway Fewerter Talend De PARICE

State Registrar

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02665 State of Maryland / Department of Health and Mental Hygiene John Edward Wetzel 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 5, 2008 0032 hrs John Edward Wetzel Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Carroll Eldersburg 1007 Sitka Spruce Lane 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Months Director unknown 49 12-07-1958 Country) 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location any Yes 2 No MD N/A Baltimore or items 23a or 28a-f sho must be notified at once. hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 2037 Deering Ave. USA 11 Marital Status
1 Never Married 2 Married 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Yes 1 Yes 2 X No specify: Specify: White If Yes, Give Yea Widowed Divorced 1. Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene.
14ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 21215-0036 N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold L. Wetzel Nancy Lee Tharle Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Linda Sweitzer, sister 2037 Deering Ave. Baltimore, MD. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition

1 Burial 2 A Cremation 3 20c. Location - City or Town, State timore, crematory or other place) Removal from Stat permit. Pages
Department of
Important: I West Arundel Crematory 04-9-08 Odenton, MD Donation 5 Other Specify Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, 21. Signature of Funeral Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Cocaine and morphine intoxication Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): n and - transit The law requires that the death certificate be executed 285, PERME, 9880 8795/08 THE 9878 4/11/08 amh Physician/Medical X UNPENDED the attending physician ted for use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 2 No Yes 2 1 🗸 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 Residence 6 🗸 Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 No 1 V Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 1 Yes 2 X No Pending the 11:30<sub>D</sub> 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1007 Sitka Spruce Lane Fidersburg, MD Sykesville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. completely filled in by 3 6 X Could not be Suicide determined (Specify) Single family residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 5, 2008 O.C.M.E. 30. Name and address of person who completed ause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner

State

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2008

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18:00 2008 Alvin March 31 Darnell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore NIA The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) 8-24-1959 **X**□M 2□F 217-78-7358 MD Director 48 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No N/A Baltimore Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 438 E. 23rd Street 21218 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2万 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MTC permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 Is marked other the any Injury or other traumatic event, the lonce. 12th grade College Case Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Boyd William Wooden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21229 333 N. Grantley Street Baltimore, MD Theresa Wooden - Wife 20b. Place of Disposition (Name of cemetery, crematory or other.pla Lorraine Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4-5-2008 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto ,MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Ceukemia month /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): 68760, Physician/Medical as attending properties for use as Box IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was a... autopsy performed? Ves 2 2 No certificate has page 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

State Registrar

within 24 the

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Priscilla Brastianos,

APR 1 0 2008

Priscilla Brastianos, Medical Doctor

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES -000

The Johns Hopkins Hospital, 600 Northwolfe Street, Maryland 21287

29d. Date signed (Month, Day, Year)

March 31, 2008

Baltimore

|   |  |                | For<br>State<br>Registrar  | State of Ma  | ryland                   |                             | rtment of   |                          |                           | lental Hy                          | giene<br>Reg. No.            | 0.8  |  | 27                   |
|---|--|----------------|--|--|--------------------------|-----------------------------|---|--------------------------|---------------------------|------------------------------------|------------------------------|--|--|----------------------|
| The s                                   | Physici  | an             | Decedent's Name (First, Middle)  | WESLEY   | ß                        |                             |   |                          |                           | 2. Date of D                       |                              | Year   | 3. Time of                                     |                      |
|   | /Medi<br>Examir  |                | 4a. Facility Name (If not institution  |  |                          |                             | 4b. City, Town,   | or Locatio               | n of Death                | AFRIL                              | 4c. Cour                     | Z∞ 8<br>ity of Death                             | 7:40   | LA M                 |
| 0                                       | Funeral  |                | 5. Social Security Jumber  | 6. Sex 7. Age  | (In yrs. las             | -                           | If Under 1 Year   | r If Und                 | er 24 Hrs.                | 8. Date of Bi                      | rth                          | N / A  | olace (State o                                 | r Foreign            |
| -                                       | Director   |                | 242-24-5774 Usual Residence of Decedent  | 1□M 2 <b>X</b> F   | 83                       | Yrs.                        | Months Days   | s Hours                  | Min.                      | 10                                 | ay, Yea <i>r)</i><br>18 24   | Cour   | ntry)  | PA                   |
|   | iryland<br>show  | _              | 10a. State 10b. County   | ,  |                          | Town or Lo                  |   |                          |                           |                                    |                              | 1  | 0d. Inside Cit                                 | -                    |
|   | the Ma<br>28a-f s<br>notified  | Director       | MD  10e. Street and Number   | N/A  | В.                       | altin                       | 10f. Zip Code   |                          |                           |                                    | 10g. Citizen o               | of What Cour                                     | t <b>\\</b> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 2 No                 |
|   | 23a or<br>ust be   | ral Di         | 1209 Windem  | ere Ave.   |                          |                             |   | L218                     |                           |                                    | US                           |  | ,  |                      |
| 936                                     | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. the matural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced  | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates: |                          |                             | Vas Decedent of<br>Yes, specify Cu                      |                          |                           | ecify Yes or N<br>Rican, etc.)     | 0- 14. R<br>B                | ace - Americ<br>lack, White,                     |  |                      |
| 15-0                                    | "natur   | Completed      | 15. Decedent'<br>(Specify only highes  | s Education<br>t grade completed)  |                          | 16a. Deced                  | ent's Usual Occ<br>kind of work don<br>OO NOT use retii | upation<br>e during m    | ost of work               | ing                                | 16b. Kind of                 | Business/In                                      | dustry   |                      |
| 212                                     | giene.<br>grene.<br>er than  | ошо            | Elementary/Secondary (0-12)  | College (1-4or 5-  | +)                       |                             | versity   |                          |                           |                                    | Hos                          | spita  | 1  |                      |
| Baltimore, Maryland 21215-0036          | 12 should be filed withir<br>h and Mental Hygiene.<br>7 is marked other than<br>traumatic event, the M   | Be             | 17. Father's Name (First, Middle, I<br>Leeandres   | •  | erry                     |                             |   |                          | hers Name<br>Mary         | (First, Middle                     | , Maiden Surn<br>Je          | <sub>ame)</sub><br>effer                         | son  |                      |
| aryl                                    | should<br>and Me<br>s mark   | D_             | 19a. Informant's Name/Relationsh   |  |                          |                             | g Address (Stree  |                          |                           | al Route Numb                      | per, City or Tow             | n, State, Zip                                    |  |                      |
| e,<br>⊠                                 | is 1 and 2<br>of Health<br>item 27 i   |                | James H. Wes   | ley-husban   |                          |                             | N. Cha  | arles                    |                           | Balt                               | imore,                       |  | 2120   | 1<br>                |
| mor                                     | Pages<br>nent of<br>int: If it   |                | 1 🛣 Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp   |  | cen                      | netery, cren                | natory or other place.                                  | i i                      |                           | 2008                               | Balti                        |  | Co.  | MD                   |
| Balti                                   | permit. Pages<br>Department of<br>Important: If in<br>arry Injury or o   |                | 21. Signature of Funeral Serviced  | Musch  |                          | 22                          | Name and Add  | ress of Fac              | ility M.F                 | ARCH F                             | /H-EAS                       | ST   | , MD   | 212                  |
| - C - C - C - C - C - C - C - C - C - C | Physician<br>/Medical<br>Examiner  |                | 23a. Part L. Enter the disease, or shook, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | Due to (or as a  | consequer                | nce of):                    | - 1 1 1 V   | ving, such a             | co U                      | or respiratory a                   | arrest,                      |  | Approximate Interval Betwoen Sola Conset and E | veen                 |
| 38760, <                                | cate be executed physician and the burial-transit  | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         | CDue to (or as a   | a consequence of):       |                             |   |                          |                           |                                    |                              |  |  |                      |
| .O. Box 6                               | requires that the death certific<br>een signed by the attending p<br>rould be detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome p<br>1 □ Live birth 2<br>4 □ Pregnant at t<br>9 □ Unknown         | ⊇ ☐ Fetal de             | eath 3                      | Ectopic pregnan<br>Other (specify)                      | су                       |                           |                                    |                              | Date of delive                                   |  | 'ear                 |
| ords, P                                 | w requires that<br>been signed I<br>should be det  | by             | Part II. Other significant condition   | ns contributing to death but   | t not resultin           | ng in the un                | derlying cause g  | iven in Par              | t I.                      |                                    | tobacco use co<br>Yes 2      |  | ne cause of de<br>pably 4 🔲 U                  |                      |
| or Vital Records,                       | The law<br>ate has b<br>page 2 sh  | Completed      |  |  |                          |                             |   | -                        |                           | 24a. Was<br>auto<br>perf<br>1□ Yes |                              | o. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | psy findings a<br>mpletion of ca<br>2 ☐ No     | available<br>luse of |
| r Vit                                   | di Si  | To Be          | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital:  | it 2 ER                  | NOutpatient                 | 3□ DOA O  | thor:                    |                           | n <i>(Check only</i>               | one)<br>idence 6 □C          | ther (Specif                                     | w)   |                      |
| o uc                                    | ffer   | ion: T         | 27. Manner of Death 1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day   | Year) 28                 | 8b. Time of<br>Injury       | 28c. Inj  | ury at<br>ork?           |                           |                                    | how injury occ               |  | //   |                      |
| Division                                | tentleath<br>tor:  | Certification: | Ž Accident investiga<br>3 □ Suicide 6 □ Could no<br>4 □ Homicide determin  | ot be  | y - At home<br>(Specify) | e, farm, stre               |   | ]Yes 2[<br>∍             |                           | 28f. Location (<br>City or To      | Street and Nur<br>wn, State) | nber or Rura                                     | l Route Numi                                   | ber,                 |
|   | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Direc<br>completely filled in by   | Medical        | 29a. Certifier (Check only one)  | Physician: To the best of xaminer: On the basis of and manner stat                     | examinatior              | edge, death<br>n and/or inv | occurred at the estigation, in my                       | time, date<br>opinion, d | and place,<br>eath occuri | and due to the<br>red at the time  | cause(s) and i               | manner as s<br>e, and due to                     | tated.<br>the cause(s                          | )                    |
| D                                       | To t<br>To t   | Σ              | 29b. Signature and title of certifier  | ZULD   | ATTEU                    | du                          |   | ise number               | 0                         |                                    | 29d. Date sign               | 3,20   | Day, Year)                                     |                      |
|   | 5  |                | 30. Name and address of person w   | ho completed cause of deal $N$ , $M$   | ath (Item 23             | ST. P                       | AUL 8   | 1                        | BAL-                      | Druo1                              | Œ                            | 2120   | 2  |                      |
|   | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) APR 1 0  | 2008 32. Registrar   | r's Signatur             | e                           | A)  |                          |                           |                                    | -                            |  |  |                      |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 200B WILDER SAMUEL MPRIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PMACE GEORGE LAUREL LAUREZ REGISWAL HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1**万**M 2□ F Hours 3 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at MARYLAND PRINCE GEORGES CO 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 r than "natural", or Items 23a or the Medical Examiner must be Funeral Was Decedent Ever in U.S. Armed Forces? . Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 Z No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 Is marked or 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Test (Street and Number of Hural House Ivalinder), Cary Street and Number of Hural House Ivalinder, Cary Street, MIN 20723

(Name of Date 20c. Location - City of Town, State MAXINE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SHILL BAPT CHURCH CEME 04-14-08 CARROLLTON, GEORGIA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC PROSTATIC CARCINOMA **Physician** MUNTITS /Medical Due to (or as a consequence of): Examiner 12 mm777 PRUSTATIC CARCINOM A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine /x pue death certificate be executed Due to (or as a consequence of) -burial-Box 68760 physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?-1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death ed by the a detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à MART HALLA 1 Yes 2 No 3 Probably 4 Unknown Completed peen PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed page certificate 1□ Yes 2□ No 2 10 Division or Vital 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera Certification: or Attending 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

31. Date filed (Month, Day, Year) APR 1 0 2008

29b. Signature and title of certifier

DAVID O. NYANJOM MD 10724 LITTLE PATURGNT PANCWAY 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 36974

29d. Date signed (Month, Day, Year)

MUL 8, 2008

GRUMSIA MO 21544

| 08-01755<br>William Rodney  |                | Title of the factor and the factor a |  |
|---|----------------|--|--|
|   |                | 1- For State Registrar Certificate of Death Reg. No. 2008  |  |
| Physicia<br>Medical Exami   | 411/           | Month Day Year   | ime of Death<br>1239 hrs                 |
| ( De  |                | William Rodney Waters March 1, 2008  4a. Facility Name (if not institution, give street and number) 727 Druid Park Lake Drive Apt.60  Baltimore  March 1, 2008  4c. County of Death Baltimore  |  |
| Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthpla   | ce (State or                             |
| Director  |                | 214-62-7771 1XM 2FF 54 Yrs. Months Days Hours Min. 10 1 53 Foreign Country   |  |
| any   |                | Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d.  | I. Inside City Limits                    |
| <b>*</b>  | Ē              | MD N/A Baltimore   | X Yes 2 No                               |
| Aaryla<br>28a-f<br>1 at or  | Director       | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |  |
| h the N<br>3a or<br>Otiffed   |                |  |  |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.   | uneral         | 11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.  | indian, Black,                           |
| after c   | by F           | 3 Widowed 4 X Spivorced If Yes, Give Year of Dates:  1 Yes 2 X No specify: Specify: Blac   |  |
| hours<br>'natur<br>Exam   |                |  | itry                                     |
| 36<br>nin 72<br>e.<br>than "dical   | plet           | Elementary/Secondary (0-12) College (1-4 or 5+)  11th N/A Drywall Finisher   |  |
| 5-00<br>ed with<br>lygien<br>other  | Completed      | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)   |  |
| 1218<br>be fill<br>ental F<br>rrked   | Be             | Bernard Charles Solomon Marion Louise Bar  | nes                                      |
| D 21<br>Should<br>Ind Me  | ٩              | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Datrice C. Paige-daughter   8 Donagh Ct. Lutherville, MD 210  |  |
| and 2.  |                | Datrice C. Paige-daughter   8 Donagh Ct. Lutherville, MD 210   |  |
| nore<br>ages i<br>at of H<br>t: If i  |                | 1 Name 2 Cremation 3 Removal from State crematory or other place)  Arbutus Mem. Pk. 3/6/2008 Baltimore   | Co. MI                                   |
| iltim<br>nit. Pa<br>artmer<br>ortani  |                | 21. Signature of Funeral Service Licensee  APDULUS Mem. PR.   3/6/2008   BaltImore   BaltImore   22. Name and Address of Facility   MARCH FUNERAL HOME   |  |
| Balt<br>permit.<br>Depart<br>Import<br>injury   |                | & lady ware 1101 E. North Ave. Baltimore, M  |  |
| Physician   |                |  | pproximate Interval<br>Between Onset and |
| /Medical<br>xaminer   |                | Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease   | Death                                    |
| 1   |                | or condition resulting in death)  Due to (or as a consequence of):   |  |
|   | ner            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |  |
|   | Examiner       | C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |  |
| nd ransit   | _              |  |  |
| Box 68760, e death certificate be execute the attending physician and ed for use as the burial - tran   | cian/Medical   | UNPENDED AMENDED   |  |
| Box 68760,<br>death certificate b<br>he attending physid for use as the bu  | /Me            | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  | Van                                      |
| x 68<br>h certii<br>tending<br>use as   |                |  | Year                                     |
| Boy<br>the att  | hysi           | 1 Yes 2 No 9 Unknown 9 Unknown   |  |
| j, P.O. E<br>ires that the d<br>signed by the   | by P           |  |  |
| ds, F   |                |  | sy findings available                    |
| cords, law requir, has been sie 2 should t  | Completed      | autopsy prior to comp  | oletion of cause of                      |
| Re<br>: The<br>ificate  |                |  | 2 No                                     |
| Vital Rec<br>hysician: The I<br>this certificate I  | Be             |  | ene                                      |
| of Vital Records, ing Physician: The law requir After this certificate has been summeral director, page 2 should  | 5              | 27 Manner of Death 28a Detect Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred   |  |
| Division of Pripital or Attending Phours after death.   | atior          | 1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)  1 Yes 2 No  |  |
| ivision or Attence after death Director:  | tific          | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural For Town, State)   | Route Number, City                       |
| Ilospital<br>24 hours 2<br>Funeral ately filled   | Certification: |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical        |  | iuse(s)                                  |
| 3 Salar   | Med            | and manner stated.  29b. Signature and title of ceptifier  29c. License number  29d. Date signed (Month,   |  |
|   |                | O.C.M.E. March 6, 2008   |  |
| OCME  |                | 30. Name and address of person who completed cause of death (Item 23a)   |  |
| 231112  |                | Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  |  |

State 31. Date filed (100 PDay) Garage

|                            |  | •              | For<br>State<br>Registrar  | State of Ma  |                          | Department of F<br>Certificate of                      |   |  | iene ) (                         | 08                        | 11730  |
|----------------------------|--|----------------|--|--|--------------------------|--|---|--|----------------------------------|---------------------------|--|
|                            | Dhusisi  |                | 1. Decedent's Name (First, Middle, Last  | ")   |                          |  |   | 2. Date of Dea<br>Month                    |                                  | Year                      | 3. Time of Death                               |
|                            | Physici<br>/Medic  |                | TASHAUN MICHAEL-A  |  | ARD                      |  |   | APRIL                                      | 2, 20                            | 800                       | 2235 <sup>M</sup>                              |
| )                          | Examin   | er             | 4a. Facility Name (If not institution, give  |  |                          |  | r Location of Death                         |  | 4c. County                       |                           |  |
|                            |  |                | HOLY CROSS HOSPIT  5. Social Security Number 6. Se   |  | (In yrs. last birt       |  | SPRING If Under 24 Hrs.                     | 8. Date of Birth                           |                                  | rGOMEI                    |  |
|                            | Funeral<br>Director  |                |  | XM 2□F   |                          | Yrs. Months Days                                       | Hours Min.                                  | (Month, Day<br>03-10-2                     | ; Year)                          | MD                        | lace (State or Foreign<br>try)                 |
|                            | land<br>Iow  |                | 10a. State 10b. County   |  | 10c. City, Town          | or Location  |   |  |                                  | 1                         | Od. Inside City Limits                         |
|                            | Man,   | ţċ             | MD PRINCE GE   | ORGE'S   | FT. WA                   | ASHINGTON  |   |  |                                  |                           | 1X Yes 2 □ No                                  |
|                            | or 28  | Director       | 10e. Street and Number   |  |                          | 10f. Zip Code  |   | 1  | log. Citizen of                  | What Coun                 | itry?  |
|                            | ath w  | ra             | 1503 OLD MUSKET L  |  |                          | 20744  |   |  | USA                              |                           |  |
|                            | er de<br>Item  | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                                |                          | 13. Was Decedent of H<br>If Yes, specify Cuba          | lispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.)          | 14. Rad<br>Bla                   | ce - Americ<br>ck, White, |  |
| 21215-0036                 | 2 should be filed within 72 hours after deeth with the Maryland and Mentle Hygiene.  and Mentle Hygiene.  americal other then "naturel", or Itema 23s or 28s-f show sumatic event, tre Medical Examinations to collise and | by             | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates:                    |                          | 1 ☐ Yes 2 🂢 No   | Specify:                                    |  | Specif                           | y: BLAC                   | CK   |
| <u>ئ</u>                   | 72 h   | Completed      | 15. Decedent's Edi<br>(Specify only highest grad   |  | 16a.                     | Decedent's Usual Occup<br>(Give kind of work done      | during most of work                         | king                                       | 16b. Kind of B                   | lusiness/Ind              | dustry   |
| 2                          | within   | mp             | Elementary/Secondary (0-12)  | College (1-4or 5   |                          | `life. DO NOT use retired                              | a)  |  | Mana                             |                           |  |
| 2                          | Hygie<br>ther<br>ther  | e Co           | 17. Father's Name (First, Middle, Last)  |  | No                       | one  | 18. Mother's Nam                            | ne (First, Middle,                         | None<br>Maiden Sumai             | ne)                       |  |
| <u>a</u>                   | S is b S   | To B           | Artavious Michael  | Love   |                          |  | Tierra                                      | Shanyce                                    | Willar                           | cd                        |  |
| Maryland                   | ges 1 and 2 should<br>t of Health and Men<br>if Item 27 ie marke<br>or other traumatic   |                | 19a. Informant's Name/Relationship (T  |  | 19b.                     | Mailing Address (Street                                |   |  |                                  |                           | Code)  |
|                            | and 2<br>Balth a<br>n 27 is  |                | Tierra Shanyce Wi  | 11ard/Mot  | her 15                   | 03 01d Musk  | tet Lane                                    | Ft. Was                                    | hingtor                          | n, MD                     | 20744  |
| ore.                       | of Heal  | 1              | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐   | Dameural from State  | 20b. Place of<br>cemeter | Disposition (Name of<br>y, crematory or other place    | ce)   | Date                                       | 20c. Location                    | - City or To              | own, State                                     |
| Ĕ                          | Pages<br>ment of<br>ent; if it<br>ury or o   |                | 4 □ Donation 5 □ Other (Specify,   |  | Resurr                   | ection Cemet   |   |  | Clinton                          | -                         |  |
| Baltimore,                 | permit. Pages<br>Department of<br>importent; if it<br>any injury or o  |                | 21. Signature of Funeral Service Linear  | emold R  | GRAY                     | 22. Name and Addre                                     |   |  | FUNERA<br>LAND, N                |                           | ME OF MD<br>0746                               |
|                            |  |                | 23a. Parti Enter the disease or comp<br>shock, or heart failure. List only of  |  |                          | 1  |   |  |                                  |                           | Approximate                                    |
|                            | Physician  |                | Immediate Cause (Final   |  |                          |  |   |  |                                  |                           | Onset and Death  15 days                       |
|                            | /Medical   |                | disease or condition resulting in death)   |  | Respira<br>consequence   | ntory Distre   | ess syndre                                  | ome  |                                  |                           | 15 days  |
| п                          | Examiner   |                | Sequentially list conditions   | b Shock  | and Acid                 | losis  |   |  |                                  |                           | 13 days  |
|                            | D #  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |  | a consequence of         |  |   |  |                                  |                           |  |
|                            | and and  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last  | U  | ely Low                  | Birthweight  | :   |  |                                  |                           | 23 days  |
| 58760,                     | ificete be executed<br>g physicien and<br>as the burial-transit  | edical E       |  |  | ks Gesta                 |  |   |  |                                  |                           | 23 days  |
| _                          | rtificet<br>ng phy<br>as th  |                | IF FEMALE:   |  |                          |  |   |  |                                  |                           |  |
| Box                        | leath certifi<br>ettending<br>I for use as   | an/h           | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome<br>1 ☐ Live birth                             |                          | 3 ☐Ectopic pregnancy                                   | ,   |  |                                  | ate of delive             | ery<br>Day Year                                |
| P.O. E                     | at the dea<br>by the el<br>tached fo   | Physician/M    | 1 Yes 2 No   | 4□Pregnant at<br>9□Unknown   | time of death            | 5 ☐ Other (specify)                                    |   |  | 1910                             | OH(I)                     | Day Iba  |
|                            | that the by detac  |                | Part II. Other significant conditions co   | ntributing to death bu   | ut not resulting in      | the underlying cause giv                               | en in Part I.                               | 23e. Did to                                | bacco use con                    | tribute to th             | ne cause of death?                             |
| Division of Vital Records, | The law requires that the death certif<br>Ite has been signed by the ettending<br>page 2 should be detached for use a  | ed by          |  |  |                          |  |   |  |                                  |                           | ably 4 Unknown                                 |
| ပ္ပ                        | e law re<br>has be<br>je 2 sho   | Completed      |  |  |                          |  |   | 24a. Was a                                 | n 24b.                           | Were auto                 | psy findings available<br>mpletion of cause of |
| Ĕ                          |  | E O            |  |  |                          |  |   | perfor                                     | med?                             | death?                    | 2 No   |
| ita<br>I                   | ilcian: The<br>certificate hi<br>rector, page  | Be (           | 25. Was case referred to medicat examiner?   |  |                          |  | 26. Place of Dear                           | th (Check only or                          | те)                              |                           |  |
| 5                          | Physi<br>this o  | 2              | 1 ☐ Yes 2 ☑ No  27. Manner of Death  | Hospital:  |                          |  | - Transmig III                              | ome 5 Resid                                |                                  |                           | y)   |
| Ę<br>G                     | ding F<br>h.<br>After<br>funera  | tion           | 1 Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Day                                  | Year) 280. I             | ime of 28c. Injur                                      | yat<br>k?<br>Yes 2 □No                      | 28d. Describe h                            | ow injury occur                  | rrea                      |  |
| 18                         | Attending Physician: or death. ector: After this certifici<br>by the funeral director,   | fica           | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Inju   | ıry - At home, fa        | rm, street, factory, office                            | 7.00 2 2 3.10                               | 28f. Location (S                           | treet and Num                    | ber or Rura               | al Route Number,                               |
|                            | rs after<br>rei Dire   | Certification: | 4 Homicide determined  | building, etc  | :. (Specify)             |  |   | City or Tow                                | n, State)                        |                           |  |
|                            | To the Hospitel or Attendit<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu  | Medicai        | 29a. Certifier  (Check only one)  Certifying Phy  Certifying P | rsician: To the best of<br>iner: On the basis of<br>and manner sta | examination and          | , death occurred at the tird/or investigation, in my o | me, date and place,<br>ppinion, death occur | , and due to the or<br>rred at the time, o | ause(s) and m<br>late and place, | anner as si<br>and due to | tated.<br>o the cause(s)                       |
|                            | To the within 2 To the complete  | ×              | 29b. Signature and title of certifier  | ,  |                          | 29c. Licens  | se number                                   |  | 29d. Date signe                  |                           | Day, Year)                                     |
|                            |  |                | Sharow Cit   | veruano,   | ne                       | D00  | 46711                                       |  | 4/3/                             | 08                        |  |
|                            | 1  |                | 30. Name and address of person who o   | ompleted cause of de   | eath (Item 23a) (        | Type, Print)   |   |  |                                  |                           |  |
|                            | 1  |                | SHARON KIERNAN   | 1500 FORE  |                          | ROAD SILVE   | ER SPRING                                   | , MD 20                                    | 910                              |                           |  |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  | 41   | ar's Signature           | 0  |   |  |                                  |                           |  |
| DH                         | MH 17 Rev 1/2  |                | APR I U 2  | 008 /600   | w the                    | Mode   |   |  |                                  |                           |  |
|                            |  |                |  |  | OF                       | RIGINAL  |   |  |                                  |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fit 878 4-10-08 vt. State of Maryland Abepartment of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APPEIL 2315 DAVID WITT 2008 4a. Facility Name (If not institution, give street and number) SEASONS 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER-HOSPICE RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/25/1936 Birthplace (State or Foreign Country) Days Months Hours 056-28-1709 NY Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD HOWARD ELKRIDGE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6150 SHADYWOOD ROAD, UNIT 106 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 🕅 No WHITE Specify Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THEODORE WITT ESTELLE SALMON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN WITT / WIFE 6150 SHADYWOOD ROAD, UNIT 106, ELKRIDGE, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State HILLTOP SERVICE CORP 04/08/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee, SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE CONGESTIVE ITEMT FAILURE Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATH if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CORONMY MITERY Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe ormed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛮 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

The law requires that the death certificate be executed physician are the burial-t Box 68760 SE attending for use as use P.O. Division or Vital Records, has certificate ha or Attending Physician: After this 124 hours after death.

The Funeral Director; Af sletch filled in by the fun Hospital within 24

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f show must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "any Injury or other traumest."

Physician

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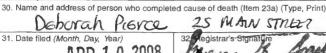
Medical

State Registrar

PIEVCE Dehurah 31. Date filed (Month, Day, Year)

APR 1 0 2008

29b. Signature and title of certifier



RUSTENTOWN ND

29c. License number

H45938

29d. Date signed (Month, Day, Year)

8th 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 2878 4-10-08 Wt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death MorAPR 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2008 Рм 3:20 YETTA WEISS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🛣 F PA 77 172-24-0336 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedcal Evac instruct be notified at any Injury or other traumatic event, the Wedcal Evac instruct be notified at any once. 1X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 3201 SZOLD DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married WHITE 1 □Yes 2 X No Baltimore, Maryland 21215-0036 Specify 2 3 Nidowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEAT PACKING 12 **BOOKKEEPER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **GOTTESMAN** EDITH SAMUEL ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3201 SZOLD DRIVE, BALTIMORE, MD LISA SEIDEL / DAUGHTER Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of OLD GEMILAS CHESED 04/06/2008 WHITE OAK, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mentet RESTIMATOR **Physician** /Medical Due to (or as a consequence of): MONTH Examiner ) MEMONIA Sequentially list conditions. Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Principle of the physician and precedents of the properties of the properties of the physician and precedents. After this certificate has been signed by the attending physician and properties. burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 KNo 3 Probably 4 Unknown 1 TYes cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 6/08 25039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 JM174 JAVOBONTS BALT. NO 32. Redstrar's Signature 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09:35 PM Jackson April 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town or Location of Death Examiner Bath more If Under 1 Year If Under 24 Hrs. emovia 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Hours 438.30.4662 Director ouisiana Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show die al Examiner must be notified at 1**X**Yes 2 ☐ No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn. Be 19a, Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tracla Bolde 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licensee There the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest for hear failure. List only one cause on each line. Immediate Cause (Final CARCINOMA RENAL CELL **Physician** 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy nerform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) UNION MEMORIAL Be HOSPITAL Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. AT 2438946-HI5 APRIL, 08, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

THYKE, M.D.

Registrar's Signature

201 EAST UNIVERSITY PARKWAY

BALTIMORE, MD\_ 21218

|                     |  |                     | 1 - For<br>State<br>Registrar   | State of M   | laryland / [   | Depa<br><i>Cei</i>  | artment of H                               | lealth and<br>Death    | Mental Hy                     | giene<br>Reg. No. | 008                                   | 73%   |
|---------------------|--|---------------------|---|--|--|---------------------|--|------------------------|-------------------------------|-------------------|---------------------------------------|---|
|                     |  |                     | 1. Decedent's Name (First, Middle, L  | ast)   |  |                     |  |                        | 2. Date of De                 | aath              |                                       | 3. Time of Death                              |
| Н                   | Physici<br>/Medio  |                     | Felton Albert Zi  | mmerman  |  |                     |  |                        | Month<br>March                | 31, 200           | Year<br>)8                            | 11:05 AM <sup>M</sup>                         |
| Š                   | Examir   |                     | 4a. Facility Name (If not institution, g  |  | •)   | -                   | 4b. City, Town, or                         | Location of De         |                               |                   | nty of Death                          |   |
|                     |  |                     | 1908 Stanley Ave  | enue   |  |                     | Rockvi                                     | 11e                    |                               | Mont              | У                                     |   |
|                     | Funeral  |                     |   | Sex 7. A   | ge (In yrs. last bir   |                     | If Under 1 Year<br>Months Days             | If Under 24 H          |                               | rth<br>av. Year)  | 9. Birth                              | place (State or Foreign                       |
|                     | Director   |                     | 202-34-2324   | 1 <b>∑</b> M 2□F   | 75   | Yrs.                |  |                        | Apr 5,                        |                   | Cuba                                  | ,,  |
|                     | pue *  |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Tow   | n or Lo             | cation                                     |                        |                               |                   |                                       | 10d. Inside City Limits                       |
|                     | Aaryti<br>aho  | ō                   | MD Montgo   | mery   |  |                     | ille                                       |                        |                               |                   |                                       | 1 ☐ Yes 2√∑ No                                |
|                     | 28a-   | ect                 | 10e. Street and Number  |  |  |                     | 10f. Zip Code                              |                        |                               | 10g. Citizen      | of What Cou                           |   |
|                     | with<br>Be or  | ā                   | 1908 Stanley Ave  | niie   |  |                     |  | 20851                  |                               |                   |                                       | ,   |
|                     | na 23  | era                 | 11. Marital Status  | 12. Was Deceden  | t Ever in U.S.   | 13. \               | Vas Decedent of Hi<br>Yes, specify Cuba    |                        | (Specify Yes or No            |                   | USA<br>Race - Ameri                   | ican Indian,                                  |
| Maryland 21215-0036 | De filed within 72 hours after deeth with the Maryland<br>hal Hyglene.<br>ed other then "naturel", or Itama 23a or 28a-f ahow<br>avent, the Medical Examinar must be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced  | Armed Forces 1 XYes 2 If Yes, Give Year or Dates:            | ]No  |                     | Yes, specify Cuba                          |                        | èrio Rican, etc.)<br>cuban    | Spe               | Black, White,<br>cify: w]             | nite  |
| Š                   | 2 hou  | Completed by        | 15. Decedent's 1  |  | 16a.   |                     | lent's Usual Occupa                        |                        |                               | 16b. Kind of      | f Business/Ir                         | ndustry unk                                   |
| 2                   | hin 7  | pe                  | (Specify only highest g<br>Elementary/Secondary (0-12)  | rade completed) College (1-4or                               | 5+)  | life. L             | kind of work done of<br>OO NOT use retired | during most of v<br>i) | vorking                       |                   |                                       | unk   |
| 7                   | d wit  | NO.                 | 12  | 4  | .,   | ha                  | ndcrafte                                   | d jewel                | er                            | <u> </u>          |                                       |   |
| 2                   | m = 0 5  | Be (                | 17. Father's Name (First, Middle, Las   |  |  |                     |  | 18. Mother's N         | lame (First, Middle           | , Maiden Surr     | name)                                 | unk   |
| Va                  | should be<br>nd Mental<br>marked c   | 2                   | Carlos Zimmer   | man  |  |                     |  |                        |                               |                   |                                       |   |
| a                   | and and le m   |                     | 19a. Informant's Name/Relationship  |  |  |                     | g Address (Street a                        |                        |                               |                   | wn, State, Zij                        | p Code)                                       |
|                     | end<br>eeith<br>m 27<br>her tr   |                     | Sandra Sweatmon   | /daugnter  | The second secon |                     | ledwood I                                  | Drive 1                |                               |                   | 240                                   |   |
| Baltimore,          | permit. Pages 1 end 2 should by Department of Heelth and Menta Important: If item 27 is marked any injury or other traumatic as <u>90ce</u> .                                    |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3   4 ☐ Donation 5 ☑ Other (Space                       | □Removal from State  | cemeter  | i Dispo<br>ry, cren | sition (Name of<br>natory or other place   | θ)                     | Date                          | 20c. Locatio      | on - City or T                        | own, State                                    |
| Balt                | permit. Page<br>Department<br>Important: If<br>any injury o  |                     | 21. Signature of Funeral Service for  | Wade, Di   | ector  | 10                  | Name and Addres                            |                        |                               | . Balt            | imore                                 | Street  |
|                     |  |                     | 26a. Part1. Enter the disease for con<br>shock, or heart failure. List only                                 | nplications that cause                                       | ed the death. Do r   | not ent             | altimore,<br>or the mode of dying          | g, such as card        | iac or respiratory a          | ırrest,           |                                       | Approximate<br>Interval Between               |
|                     | Physician  |                     | Immediate Cause (Final  | A C.   |  |                     |  |                        |                               |                   | 1                                     | Onset and Death                               |
|                     | /Medical   |                     | disease or condition resulting in death)  | a. Due to (or a  | s a consequence  | of):                |  |                        |                               |                   | DI                                    | 7 <del></del>                                 |
|                     | Examiner   |                     | Commendation line and distance  | b  |  |                     |  |                        |                               |                   |                                       | 2   |
|                     | D ==   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |  | s a consequence  | of):                |  |                        |                               |                   |                                       |   |
|                     | acute<br>ind<br>trans  | Examiner            | Cause (Diseese or injury that initiated events resulting in death) Last                                     | c  |  |                     |  |                        |                               |                   |                                       |   |
| 8/60,               | cate be executed<br>physicien and<br>the burial-transit  | Ē                   | Tooding in death) cast  | Due to (or as  | s a consequence  | or):                |  |                        |                               |                   |                                       |   |
| 200                 | es es  | dical               | •   | d  | ·  | <del></del>         |  |                        |                               |                   |                                       |   |
| ×                   | eath certifii<br>ettending r<br>I for use as   | /Me                 | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   | e of pregnancy   |                     |  |                        |                               | 234               | Date of deliv                         | 1904  |
| O. BOX              | at the death certifi<br>by the ettending<br>tached for use as  | Physician/Me        | in the past 12 months?  1  Yes 2 No 9 Unknown   | 1☐Live birth   | 2 ☐ Fetal déath<br>at time of death  |                     | Ectopic pregnancy<br>Other (specify)       |                        | -                             |                   | Month                                 | Day Year                                      |
| ž.                  | res that i<br>igned by<br>be deta  |                     | Part II. Other significant conditions   | contributing to death  | but not resulting in   | n the ur            | iderlying cause give                       | en in Part I.          | 23e. Did                      | tobacco use co    | ontribute to t                        | the cause of death?                           |
| Hecords             | law requires that<br>es been signed b<br>2 should be deta  | sted by             |   |  |  |                     |  |                        | _ 1_                          | Yes 2□No          | 3 ☐ Prof                              | bably 4 Unknown                               |
| S<br>E<br>E         | sicien: The law<br>certificate hes b<br>irector, page 2 s  | Completed           |   | - · · · -  |  |                     |  |                        | 24a. Was                      |                   | b. Were auto<br>prior to co<br>death? | opsy findings available ompletion of cause of |
| _                   | n: Ti<br>ficate<br>or, pa  | e Co                | 25. Was case referred to medical  | 1  |  |                     | <del></del>                                |                        | 1 ☐ Yes                       | 28 No             | 1 🗆 Yes                               | 2□ No -                                       |
| 5                   | sician:<br>certific<br>lirector,   | 8                   | examiner?   | Hospital: 1 ☐ Inpati   | iont 2 PP/O  | anation.            | Othe                                       | \r                     | Death (Check only             |                   | 21 (2                                 |   |
| ō                   | ding Phys<br>h.<br>After this<br>funeral dis   | . To                | 27. Manner of Death   | 28a. Date of Inj   | ury 28b. 1   | Time of             | 28c, Injury                                | at                     | 28d. Describe                 | how injury occ    |                                       | <i>'ty)</i>                                   |
| 5                   | th.  | tion                | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Da   | ay Year) II  | njury               | Work                                       | (?<br>Yes 2∐No         |                               |                   |                                       |   |
| UIVISION            | e Hospital or Attanding Physician:<br>24 hours eller death.<br>E Funeral Director: Afler this certificiety filled in by the tuneral director,                                    | Certification;      | 3 ☐ Suicide 6 ☐ Could not determine   | 289. Place of in   | njury - At home, fa<br>htc. (Specify)  | rm, str             | eet, factory, office                       |                        | 28f. Location (<br>City or To | Street and Nu     | mber or Run                           | al Route Number,                              |
| 2                   | pital o  |                     | 29a. Certifier 1 Certifying P   |  |  |                     |  |                        |                               |                   |                                       |   |
|                     | To the Hospital or Attent within 24 hours effer deatl To the Funeral Director; completely filled in by the   | Medicai             | (Check only 2 Medical Exa   | hysician: To the besi<br>minar: On the basis<br>and manner s | of examination and   | d/or inv            | estigation, in my op                       | pinion, death oc       | ccurred at the time,          | date and plac     | manner as s<br>e, and due t           | stated.<br>to the cause(s)                    |
|                     | To the within To the compl   | Σ                   | 29b. Signature and title of certifier   | ()   |  |                     | 29c. License                               |                        |                               | 29d. Date sig     | ned (Month,                           | Day, Year)                                    |
|                     |  |                     | Am 2  | Seck   | 1 m D  | me                  | 700  | 728                    | + 0                           | KpT,              | 7 2                                   | 000   |
|                     |  |                     | 30. Name and address of person who  | OLINP N  | n nmi  |                     | S/11/                                      | er Go                  | Vical 1                       | mo                | DY                                    | 102   |
| -                   | Sta<br>Registr   |                     | 31. Date filed (Month Day, Year) 20   | 08 Regist  | trar's Signature   | fra                 | de)  |                        |                               |                   |                                       |   |

| 08-02272<br>Emmanuel Adel  | oisi <i>i</i>    |  |                      | e or Print in<br>ate of Maryla       |  |                                  |                                      |                  |                   |                                     | ible.                   |                |  |
|--|------------------|--|----------------------|--------------------------------------|--|----------------------------------|--------------------------------------|------------------|-------------------|-------------------------------------|-------------------------|----------------|--|
|  |                  | 1- For State<br>Registrar  |                      |                                      |  | rtificate o                      |                                      |                  | ,,,               |                                     | 3. No. 20               | 0 (            | 8 1173   |
| Physicia<br>Medical Exami  |                  | 1. Decedent's Name ( EMMANUEL  | ADEBI                | SI AKANDI                            |  |                                  |                                      |                  | Mor<br>Mar        | e of Death<br>oth<br>ch 22,         | Day Year<br>2008        |                | 3. Time of Death<br>1440 hrs                   |
|  |                  | 4a. Facility Name (if n  |                      |                                      | ımber)   |                                  | 4b. City, Town,<br>Lanham            | or Location of I | Death             | 4c. County of Death Prince George's |                         |                |  |
| Funeral  |                  | 5. Social Security Nur   | mber                 | 6. Sex                               | 7. Age (In yrs.                                | last birthday)                   | If Under 1 Y                         |                  |                   | ate of Birth                        | (MM/DD/YYYY)            |                |  |
| Director   |                  | 224-23-33  | 325                  | 1XX <sub>M</sub> 2 F                 | 6  | 67 <sub>Yr</sub>                 |                                      | ays Hours        | Min. 03           | /17/                                | 1941                    | Foreigr<br>Cou | ntry) NIGERIA                                  |
| Ŷu   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                      |                                      |  |                                  |                                      |                  |                   |                                     |                         |                | 10d. Inside City Limits                        |
| Maryland<br>28a-f show any<br>d at once.   | 7                | MD   | PRINC                | E GEORGES                            | LAN  | MAH                              |                                      |                  |                   |                                     |                         |                | 1 X Yes 2 No                                   |
| Maryla<br>- 28a-f  | Director         | 10e. Street and Numb   |                      |                                      | <b>-</b>                                       |                                  | 10f. Zip Code                        |                  |                   | 10                                  | g. Citizen of Wha       | t Coun         | try?   |
| ith the<br>23a or  | al Di            | 6906 WOOD  | STREA                |                                      |  |                                  | 20706                                |                  | 0.40              |                                     | NIGERIA                 |                |  |
| and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.                             | Funeral I        | 1 X Never Married  | 2 M                  | arried Armed F                       |  |                                  | as Decedent of I<br>Yes, specify Cub |                  |                   |                                     | White,                  |                | can Indian, Black,                             |
| after d  | by F             | Specify: Spe |                      |                                      |  |                                  |                                      |                  |                   |                                     |                         |                |  |
| 2 hours<br>"natur<br>Exam  |                  | 15. Decedent's Educ  |                      | cify only highest gra                |  |                                  | nt's Usual Occu<br>nost of working I |                  |                   | ne                                  | 16b. Kind of Busi       | ness/Ir        | ndustry  |
| 5-0036<br>lled within 72<br>Hygiene.<br>I other than   | Completed        | Elementary/ occorre  | 201 <b>y</b> (0-12)  | 4 YEAR                               | ,  | PASTO                            | ₹                                    |                  |                   |                                     | PRIVATE                 |                |  |
| 15-0<br>iiled wi<br>Hygie<br>d other   | Col              | 17. Father's Name (Fi  |                      |                                      | *  |                                  |                                      |                  |                   |                                     | aiden Surname)          |                |  |
| 2121<br>ould be fil<br>Mental E<br>marked  | To Be            | DAVID FAT  19a. Informant's Name   |                      |                                      |  | 19b. Mailir                      | ng Address (St                       |                  | AIL OY            |                                     | E<br>ber, City or Town, | State.         | Zip Code)                                      |
| e, MD 21215-003<br>1 and 2 should be filed within<br>Health and Mental Hygiene,<br>item 27 is marked other the<br>r traumatic event, the Me.   |                  | MARY AKAN  |                      |                                      |  |                                  |                                      |                  |                   |                                     | MD 2077                 |                | ,  |
| ore, MI<br>es 1 and 2.<br>of Health a<br>of Health a<br>of Heatth a  | П                | 20a. Method of Dispos  | -                    | 3 Removal fr                         |  | Place of Dispo<br>crematory or o | sition (Name of<br>ther place)       |                  | Date              | 2000                                | 20c. Location - C       | •              |  |
| Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr  |                  | 4 Donation 5   | Other Sp             | ecify:                               | FT   | _                                | LN CEME                              | ILKI             |                   |                                     | BRENTWO                 |                |  |
| Bal<br>permi<br>Depar<br>Impo<br>injur   |                  | 21. Signature of Fune  | rai Service          | 210de                                | rich   |                                  |                                      |                  |                   |                                     | NS FUNER<br>VER, MD     |                | _  |
| Physician  |                  | 23a. Part I. Enter the of failure. List only   |                      |                                      | aused the death                                |                                  |                                      |                  |                   |                                     |                         |                | Approximate Interval<br>Between Onset and      |
| 'Medical<br>kaminer  |                  | Immediate Cause (Fir or condition resulting  | nal disease          | <sub>a.</sub> Hypertensi             |  |                                  | liovascular D                        | isease           |                   |                                     |                         |                | Death  |
| ,  |                  | Sequentially list condi  |                      | b                                    | consequence                                    | 01):                             |                                      |                  |                   |                                     |                         |                |  |
|  | iner             | if any, leading to imme<br>cause. Enter Underly  | ediate<br>ving Cause |                                      | consequence                                    | of):                             |                                      |                  |                   |                                     |                         |                |  |
| ecuted<br>and<br>- transit   | Examine          | (Disease or injury that<br>events resulting in de-   |                      | Due to (or as a                      | consequence                                    | of):                             |                                      |                  |                   |                                     |                         | 7              |  |
| be exectician article 1.   | dica             | UNPENDED   |                      | AMENDED                              |  | -                                |                                      |                  |                   |                                     |                         |                |  |
| Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be ex 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician tely filled in by the funeral director, page 2 should be detached for use as the burial. | sician/Medical   | IF FEMALE:<br>23b. Was decedent pre<br>past 12 months?   | egnant in th         | e 1 Live                             | outcome of preg<br>pirth<br>nant at time of de | 2 F                              | ota: dout                            | B Ectopic p      | regnancy          |                                     | 23d. Date of d<br>Month |                | ay Year  |
| Box<br>e death<br>the atte   | ysic             | 1 Yes 2 No   | 9 Unk                | 7                                    |  | eath 5 O                         | ther (Specify)                       |                  |                   |                                     |                         |                |  |
| P.O. es that the gned by t   | Completed by Phy | Part II. Other signific Diabetes Mel   |                      | ons contributing to                  | death but not                                  | resulting in the                 | underlying caus                      | e given in Part  |                   |                                     | oacco use contrib       | _              | the cause of death?                            |
| Division of Vital Records, P.C tal or Attending Physician: The law requires that is after death.  In Director: After this certificate has been signed be led in by the funeral director, page 2 should be detained in by the funeral director, page 2 should be deata  | letec            |  |                      |                                      | -  |                                  |                                      |                  | 24                | la. Was a                           |                         |                | topsy findings available ompletion of cause of |
| tal Reco   | g mo             |  |                      |                                      |  |                                  |                                      |                  | -   <sub>15</sub> | perform                             | med? de                 | ath?<br>✓ Ye   |  |
| Vital Rec<br>sysician: The l<br>this certificate l   | BeC              | 25. Was case referred examiner?  | to medical           | Hospital:                            |  |                                  | 26.Pia                               | ce of Death (C   | heck only on      | e)                                  |                         |                |  |
| n of Viding Physical  After this funeral dir   | ျ                | 1 ✓ Yes 2<br>27. Manner of Death   | No                   | 28a. Date                            | of Injury                                      | ER/Outpatien<br>28b. Time of     |                                      | Other 4 I        | Nursing Home      | hanned                              | Residence 6 🗸           |                | : Scene  |
| OD C<br>cending<br>sath.<br>or: Af   | ţį               |  | Pend                 | ing (Month                           | , Day,Year)                                    |                                  | · ·   _                              | Yes 2 N          | - 1               |                                     |                         |                |  |
| IVISI<br>or Att<br>after de<br>Direct  | Certification:   | 2 Accident 3 Suicide 6   | Could                | not be                               | e of Injury - At h                             | nome, farm, stre                 | et, factory, office                  | building, etc.   |                   | cation (S                           |                         | r or Rui       | ral Route Number, City                         |
| Divisior Hospital or Attence 24 hours after death Funeral Director:  |                  | 4 Homicide   | _                    | mined (Specify)                      | -  |                                  |                                      |                  |                   |                                     |                         | _              |  |
| To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical          | (Check only  |                      | ysician: To the bes                  | of examination a                               |                                  |                                      |                  |                   |                                     |                         |                |  |
| F. ½ 5 8   | Me               | 29b. Signature and Itl   | e of certifie        | and manner s                         | tateu.   |                                  | 29c. Lice                            | nse number       |                   |                                     | 29d. Date signe         | d (Mor         | nth, Day, Year)                                |
|  |                  |  |                      |                                      |  |                                  | 0.0                                  | C.M.E.           |                   |                                     | March 23, 2             | 800            |  |
| PGO OCME   |                  | 30. Name and press Mary G. Ripple  |                      | who completed caus<br>Deputy Chief I |  |                                  | 1 Penn Stre                          | et, Baltimor     | e, MD 21          | 201                                 |                         |                |  |
|  | -                | 31. Date filed (Month,   | Day, Year)           |                                      | egistrar's Signat                              |                                  |                                      | -                |                   |                                     |                         |                |  |
| Regist   | rar              | MAR 2 6  | 2008                 | Been                                 | A 1  | grave.                           |                                      |                  |                   |                                     | -                       |                |  |

Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 8:10 A. M March 24 Mariorie Byrd 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartland Health Care Center Prince George's Adelphi 7. Age (In yrs. last birthday) 8. Date of Birth 11/25/1936 Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Anderson Co., S.d. Director 577-54-5576 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Director Md. Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20784 U.S.A. Funeral 5129 70th Place 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Stock Clerk Merchandising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James David Byrd Ella Wease Eldridge 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda D. Robinson/Daughter 5129 70th Pl., Hyattsville, Md. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 04/01/08 Landover, Maryland 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21, Signature of Funeral Service Licensee, x any N. I A all 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer s Dementia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the first linder in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy performe 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖺 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician ned by the atter

with the Maryland

death v

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any injury or other traumatic event. the Manical Event

Baltimore, Maryland 21215-0036

an "natural", or items 23a or 28a-f show Medical Ex miner must be notifled at

Certification: To

s after death. filled in by the To the Hospital within 24 hours a To the Funeral L

State

Registrar

Medical

29b. Signature and title of certifier

29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0058290

29d. Date signed (Month, Day, Year) March 27,2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Muttath, M.D., 5711 San 32. Registrar's Signatur 5711 Sarvis Avenue # 200, Riverdale, Maryland 20737

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

MAR 2 8 2008

6 ☐ Could not be



/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

Baltimore, Maryland 21215-0036

/Medical

| nine     | 4  | AnneArund  | el Med             | ical Cent                           | er   |                        | Anna                     | ро1і                             | is                 |   |   | Anne                         | Arunde                         | e1               |         |
|----------|--|--|--------------------|-------------------------------------|--|------------------------|--------------------------|----------------------------------|--------------------|---|---|------------------------------|--------------------------------|------------------|---------|
| al<br>or |  | 5. Social Security Nu<br>456-96-77   | umber              | 6. Sex<br>1 □ M 2 🔀 F               | 7. Age (In yrs. 59                               | last birthday)<br>Yrs. | If Under<br>Months       | 1 Year                           | If Under<br>Hours  | 24 Hrs.<br>Min.                               | 8. Date of Birt<br>(Month, Day<br>Dec. 13 | h<br>y, Year)<br>8.1948      | 9. Birthpla<br>Counti<br>Texas | . ,              | oreign  |
|          |  | Usual Residence of Decedent  |                    |                                     |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
| ١,       |  | 10a. State   | 10b. County        |                                     |  | y, Town or Lo          | cation                   |                                  |                    |   |   |                              | 10                             | d. Inside City L |         |
|          | runeral Director   | MD   | Anne A             | rundel                              | Ann  | apolis                 |                          |                                  |                    |   |   |                              |                                | 1 <b>X</b> Yes 2 |         |
| 1        |  | 01/01  |                    |                                     |  |                        |                          |                                  |                    | 10g. Citizen of                               | f What Counti                             | ry?                          |                                |                  |         |
| 3        | ig i   | 3206 Hens  | on Ave             | nue                                 | 0 40.1   |                        | 1401                     |                                  | i=i=0 / <b>C</b> = | asifu Van an Na                               | USA                                       | Race - American Indian,      |                                |                  |         |
|          |  | <ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>   | i                  |                                     |  | an, Mexica             | n, Puerto                | ecify Yes or No-<br>Rican, etc.) | Bla                | lace - American Indian,<br>Black, White, etc. |   |                              |                                |                  |         |
| 1        | 2  | 3 ☐ Widowed  |                    | 1 □ Yes                             | 2 <b>⊈N</b> o                                    | Specify.               |                          |                                  | Spec               | Specify: Black                                |   |                              |                                |                  |         |
| 170      | Completed  | (Speci   | 15. Decedent       | 's Education<br>et grade completed) |  | 16a. Deced             | dent's Usua              | al Occup                         | ation              | et of work                                    | ina                                       | 16b. Kind of                 | Business/Indu                  | ustry            |         |
| 1 3      | E P  | Elementary/Secon   |                    | College (                           |  | _                      | kind of woi<br>DO NOT us |                                  |                    | ,   | ,,,g                                      |                              |                                |                  |         |
| 8        | 3  | 12   | First thirty       | ( 4)                                |  | Of                     | fice                     | Mana                             |                    | or's Alams                                    | e (First, Middle,                         | Real E                       |                                |                  |         |
| á        | e<br>D   | 17. Father's Name (  Andrew P  |                    | Last)                               |  |                        |                          |                                  | _                  |   |   | waluen Surna                 | arne)                          |                  |         |
| ŀ        | 2  | 19a. Informant's Na  |                    | nin (Tyne Print)                    |  | 19b Mailir             | na Address               | (Street                          |                    |   | Nunn<br>al Route Numbe                    | er City or Tow               | n State Zin (                  | Code)            |         |
| ı        | -  |  |                    |                                     |  |                        | Ü                        | ,                                |                    |   | st Wash                                   |                              |                                |                  |         |
| 10       | 1  | Alicia Lo<br>20a. Method of Disp   |                    | Daugnter                            | 20b. F   | Place of Dispo         |                          |                                  |                    |   | Date                                      | 20c. Location                |                                | _                |         |
|          |  | 1 ☐ Burial 2 ☐<br>4 ☐ Donation   |                    | 3 □Removal from<br>pecify)          |  | esapeal                |                          |                                  |                    | 03/26   | 72008                                     | Beltsv                       | ille.M                         | arv1and          | 4       |
|          | ŀ  | 21. Signature of Ph  |                    |                                     | 922  | 22                     | 2. Name an               | d Addre                          | ss of Facil        | ity Mc  | Guire F                                   | uneral                       | Service                        | ce, Inc          | •       |
|          |  | Ch   | rdré d             | Thomas                              | al   | 74                     | 00 Ge                    | orgi                             | ia Av              | enue  | , North                                   | West W                       | Vashing                        | gtonDC           | 2001    |
|          |  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                    |                                     |  |                        |                          |                                  |                    |   |   |                              | Approximate<br>Interval Betwe  | en               |         |
| ı        | Immediate Cause (Final disease or condition SGDS 1.5               |  |                    |                                     |  |                        |                          |                                  |                    |   |   |                              | Onset and Dea                  | atri             |         |
|          | resulting in death)  Due to (or as a consequence of):              |  |                    |                                     |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
| ı,       | Sequentially list conditions,  b. Due to (or as a consequence of): |  |                    |                                     |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
|          |  | Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury  |                    |                                     |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
|          | Examine  | that initiated events resulting in death) L  | ast                | c<br>Due to                         | (or as a conseq                                  | uence of):             |                          |                                  |                    |   |   |                              |                                |                  |         |
| 1        | Can  |  |                    | d                                   |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
| A CALL   | Physician/imedical   | IE EEMALE:   |                    |                                     |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
| 100      | any  | IF FEMALE:<br>23b. Was decedent  | pregnant           |                                     | tcome pf pregna<br>birth 2  Feta                 |                        | Ectopic pr               | regnancy                         | /                  |   |   |                              | Date of deliver                | ry<br>Day Yea    | ar      |
| 13       | Sic  | in the past 12<br>1 ☐ Yes 21<br>9 ☐ Unknown  | ]No                | 4□Preg<br>9□Unkr                    | nant at time of o                                | leath 5                | Other (sp                | ecify)                           |                    |   |   | -   "                        | vioriti) i                     | Day 10           | ai .    |
|          |  | Part II. Other signifi   | icant condition    | ons contributing to c               | leath but not res                                | ultina in the u        | nderivina c              | ause giv                         | en in Part         | I.  | 23e. Did t                                | obacco use co                | ontribute to the               | e cause of dea   | ath?    |
| - 1 -    | y D  | J  |                    | 3                                   |  | J                      | , ,                      | J                                |                    |   | 1 🗆 '                                     | Yes 2 No                     | 3 ☐ Proba                      | ably 4 XUnl      | known   |
| 13       | Completed  |  |                    |                                     |  |                        |                          |                                  |                    |   | 24a. Was                                  | an   24h                     | n Were auton                   | sy findings av   | ailable |
| 1        | Ē  |  |                    |                                     |  |                        |                          |                                  |                    |   | autoj<br>perfo                            | osy<br>ormed?                | prior to com<br>death?         | npletion of cau  | se of   |
| 000      | 5  | 25. Was case referr  | ed to medical      |                                     |  |                        |                          |                                  | 26. Plac           | e of Deat                                     | 1 Yes<br>h (Check only o                  | 2 No                         | 1 ☐ Yes                        | 2 □ No           |         |
| F        | 0  | examiner?<br>1   | No                 | Hospital:                           | Mipatient 2 □                                    | ER/Outpatier           | nt 3 DC                  | OA Oth                           | or:                |   | me 5 Resi                                 |                              | Other (Specify                 | ·)               |         |
|          |  | 27. Manner of Death  | 5 ☐ Pendin         | 28a. Date                           | of Injury  | 28b. Time o<br>Injury  | f 2                      | 28c. Injur<br>Wor                |                    | · · ·   | 28d. Describe                             |                              |                                |                  |         |
| 1        | iatio  | 2 ☐ Accident   | investig           | ation                               |  |                        | М                        |                                  | Yes 2 □            | No No   |   |                              |                                |                  |         |
| 1919     |  | 3 ☐ Suicide<br>4 ☐ Homicide  | determ             | I Zoe. Plac                         | e of injury - At h<br>ling, etc. <i>(Speci</i> i | ome, farm, str<br>fy)  | eet, factory             | y, office                        |                    |   | 28f. Location (2<br>City or To            | Street and Nur<br>vn, State) | mber or Rural                  | Route Numbe      | er,     |
| 0        | Medical Certification:   | 29a. Certifier   | 1 Cartifuin        | g Physician: To th                  | e hest of my kno                                 | wledne deat            | h occurred               | at the ti                        | me date a          | nd place                                      | and due to the                            | cause(s) and                 | manner as at                   | ated             |         |
| 100      | alca   |  |                    | Examiner: On the I                  |  |                        |                          |                                  |                    |   |   |                              |                                |                  |         |
| BA       | Me   | 29b. Signature and   | title of certifier | (A)                                 |  |                        |                          |                                  | e number           |   |   | 29d. Date sign               | ned (Month, L                  | Day, Year)       |         |
|          |  |  | theol              | a Clay                              | omo  |                        |                          | D5                               | 851                | 0   |   | 3/1                          | 9/08                           | 5                |         |
|          |  | 30. Name and addre   |                    | who completed cau                   | 11010  | 217                    | 4                        | 41                               | MC                 | 200<br>An                                     | 01 Medi<br>napolis                        | cal Par<br>, Maryl           | ck Way<br>Land 21              | L401             |         |
| tate     | е .  | 31. Date filed (Mont   |                    |                                     | egistrar's Signa                                 | ature                  |                          | 7 1 1 T                          |                    |   | -   | -                            |                                |                  |         |
| tra      |  | MA   | AR 27              | 2008                                | legistrar's Signa                                | S. As                  | sali)                    |                                  |                    |   |   |                              |                                |                  |         |

Registrar

|  |  | 1 _ State  |  | rtment of Health and tificate of Death   |  | 21111   | 8 1 734   |
|--|--|--|--|--|--|---|---|
|  |  | Registrar  1. Decedent's Name (First, Middle, Last)  | Cel  | incate of Death  | 2. Date of Death   | 3. No. C. O O   | 3. Time of Death  |
| Physicia   |  | 2330   | D•   |  | Month  | Day Ye  | ar  |
| /Medic   | - 4  | Everett Glenn  4a. Facility Name (If not institution, give street and number)  | Bowi   | e<br>4b. City, Town, or Location of D  | Marcheath  | 26, 2008<br>4c. County of D   |   |
| Examin   | er   | 11812 Fort Washington Road   |  | Fort Washingt  |  |   | e Georges   |
| Funeral  |  |  | s. last birthday)  | If Under 1 Year   If Under 24 I  | Hrs. 8. Date of Birth  | 9.  | Birthplace (State or Foreign  |
| Director   |  | 220-16-7799 <sup>1</sup> XM 2□F 80   | Yrs.   | Months Days Hours M  | Min. (Month, Day, May 15,  |   | Country)<br>Maryland  |
| - A-   |  | Usual Residence of Decedent  |  |  | , 11dy 159   | 1721  |   |
| ream and wenter trygene.  man z7 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at |  | 10a. State 10b. County 10c. C  | City, Town or Lo   | cation   |  |   | 10d. Inside City Limits   |
| a-f s  | cto  | MD Prince Georges  | Fort Wa  | shington   |  |   | 1 ☐ Yes 2 X No  |
| or 28<br>e no  | Director   | 10e. Street and Number   |  | 10f. Zip Code  | 10   | g. Citizen of What  | Country?  |
| 23a<br>ist b   |  | 11812 Fort Washington Road   |  | 20744  |  | USA   |   |
| ems<br>er mi   | Funeral  | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | U.S. 13. V   | Vas Decedent of Hispanic Origin?<br>f Yes, specify Cuban, Mexican, P   | ? (Specity Yes or No-<br>uerto Rican, etc.)  |   | merican Indian,<br>Vhite, etc.  |
| or le  |  | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No   |  | ☐ Yes 2 No Specify:  | ,  | Specify:  | White   |
| ıral",   | d by   | 3 ∑Widowed 4 □ Divorced Year or Dates:   |  |  |  |   |   |
| "natu  | Completed  | <ol> <li>Decedent's Education<br/>(Specify only highest grade completed)</li> </ol>  | 1 (Give  | ent's Usual Occupation<br>kind of work done during most of   | working 1  | 6b. Kind of Busine  | ess/Industry  |
| han<br>e Me  | ם  | Elementary/Secondary (0-12) College (1-4or 5+)   |  | OO NOT use retired)  |  | _   |   |
| t tr   |  | 1.2   17. Father's Name (First, Middle, Last)  | Seni   | or Executive VP  | Name (First, Middle, M   | _   | nd Entertain  |
| ever<br>ever   | Be   | , , ,  |  |  |  | ,   |   |
| narke<br>natic   | 유  | Allard Norris Bowie  | 484 ***  |  | Virginia G   |   |   |
| raun   |  | 19a. Informant's Name/Relationship (Type. Print) Bonita Barger/Daughter  | <b>I</b>   | g Address (Street and Number o<br>Gwynndale Driv   |  |   | te, Zip Code)   |
| ther t   |  |  | . Place of Dispos  |  |  | Oc. Location - City   | or Town State   |
| Important: If frem 27 is<br>any Injury or other trau<br>once.  |  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  | cemetery, cren   | natory or other place)   |  | •   | ·   |
| tant;  |  |  |  | urch Durham 3/   |  |   | ,Maryland   |
| ny Ir  |  | 21. Signature of Funeral Service Licensee M00945   | A A  | Name and Address of Facility rehart—Echols F   | uneral Home  | P.A.  |   |
| = 60   |  | 23a. Part1. Enter the disease, or complications that caused the de   | 2  | 11 St. Mary's A  | ve. La Plat  | a,MD 20   | )645<br>Approximate   |
| miner  |  |  |  |  |  |   |   |
| ian and<br>urial-transit   | l Examiner   | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a conservation of the conservat |  |  |  |   |   |
| by the attending physicia<br>ached for use as the bur  | dical  | if any, leading to infinedate cause. Enter Underlying Cause (Disease or injury that initiated events   | equence of): gnancy etal death 3 □   | Ectopic pregnancy<br>Other (specify)   |  | 23d. Date of<br>Month   | delivery<br>Day Year  |
| y the attending physicia<br>ached for use as the bur   | by Physician/Medical                                       | If any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   C   | equence of): gnancy stal death 3 [ f death 5 [   | Other (specify)  | 23e. Did toba<br>1 □ Ye:   | Month   | Day Year te to the cause of death?  |
| ate has been signed by the attending physicia<br>page 2 should be detached for use as the bur  | Physician/Medical  | If any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | equence of): gnancy stal death 3 [ f death 5 [   | Other (specify)  | 1 Tyes  24a. Was an autopsy perform  | Month  acco use contribut  s 2 No 3 2   | Day Year  te to the cause of death?  Probably 4 to Unknown  e autopsy findings available to completion of cause of  |
| ate has been signed by the attending physicia<br>page 2 should be detached for use as the bur  | Be Completed by Physician/Medical                          | If FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant conditions contributing to death but not received by the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant conditions contributing to death but not received by the past 12 months?  25c. Was case referred to medical examiner?   | gnancy etal death 3 f death 5 cesulting in the un  | Other (specify)  aderlying cause given in Part I.  | 1 Tyes  24a. Was an autopsy perform  | Month  acco use contributes 2 No 3 2  24b. Were prior deat deat   | Day Year  te to the cause of death?  Probably 4 trunknowr  e autopsy findings available to completion of cause of   |
| this certificate has been signed by the attending physicia director, page 2 should be detached for use as the bur  | To Be Completed by Physician/Medical                       | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  23c. If yes, outcome pf pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  24c. If yes, outcome pf pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  25c. Was case referred to medical examiner?  1 □ Yes 2 □ No  1 □ Inpatient 2   | gnancy etal death 3 control f death 5 control esulting in the un   | Other (specify)  addriving cause given in Part I.  26. Place of t 3 DOA Other: 4 Nursin  | 1  Yes  24a. Was an autopsy perform 1  Yes 2  Death (Check only one and Home 5 X Resider   | Month  acco use contribut  a 2 No 3   24b. Wer  prior  deat 1   )  acco 6 Other (3)   | Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available to completion of cause of th? Yes 2 No  |
| Affer this certificate has been signed by the attending physicia<br>uneral director, page 2 should be detached for use as the bur                          | To Be Completed by Physician/Medical                       | If repairing to infinite directors cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | equence of):  gnancy etal death 5 f death 5 esulting in the ur   | 26. Place of t 3 DOA Other: 4 Nursin Work?   | 24a. Was an autopsy perform  1 Yes 2  Death (Check only one  | Month  acco use contribut  a 2 No 3   24b. Wer  prior  deat 1   )  acco 6 Other (3)   | Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No   |
| irector: After this certificate has been signed by the attending physicia in by the funeral director, page 2 should be detached for use as the bur         | To Be Completed by Physician/Medical                       | If FEMALE:   23c. If yes, outcome pf pregrant in the past 12 months?   1   Ves 2   No   No   No   No   No   No   No  | gnancy etal death 5 esulting in the un  ER/Outpatien 28b. Time of Injury   | 26. Place of t 3 DOA Other:  28c. Injury at Work? M 1 Yes 2 No   | 1  Yes  24a. Was an autopsy perform 1  Yes 2  Death (Check only one ng Home 5 🕱 Resider  28d. Describe how   | Month  acco use contribut  a 2 No 3  24b. Wen prior deat  (a)  acco 6 Other (a)  w injury occurred  | Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No   |
| irector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the bur           | Certification: To Be Completed by Physician/Medical        | If any, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | gnancy etal death 3 f death 5 esulting in the un ER/Outpatien 28b. Time of Injury chome, farm, strectify)  | 26. Place of  27. Specify)  28. Injury at Work?  M 1 Yes 2 No  28. No eet, factory, office   | 1 ☐ Yes  24a. Was an autopsy perform 1☐ Yes 2  Death (Check only one ng Home 5 ☒ Resider  28d. Describe how  28f. Location (Str. City or Town,   | Month  acco use contribut | Day Year  te to the cause of death?  Probably 4 In Unknown e autopsy findings available to completion of cause of th? Yes 2 No  Specify)  Tr Rural Route Number, er as stated.                        |
| irector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the bur           | To Be Completed by Physician/Medical                       | If any, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | gnancy etal death 3 f death 5 esulting in the un ER/Outpatien 28b. Time of Injury chome, farm, strectify)  | 26. Place of  27. Specify)  28. Injury at Work?  M 1 Yes 2 No  28. No eet, factory, office   | 1 ☐ Yes  24a. Was an autopsy perform  1☐ Yes 2  Death (Check only one ng Home 5 ☒ Resider  28d. Describe how  28f. Location (Str. City or Town, one ng Home at the time, decourred at   | Month  acco use contribut | Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available t to completion of cause of th? Yes 2 No  Specify)  Transl Route Number, er as stated, due to the cause(s)       |
| irector: After this certificate has been signed by the attending physicia<br>n by the funeral director, page 2 should be detached for use as the bur       | edical Certification: To Be Completed by Physician/Medical | If any, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | gnancy etal death 3 f death 5 esulting in the un ER/Outpatien 28b. Time of Injury chome, farm, strectify)  | 26. Place of  27. DOA  28. Doal  28. Doal  29. | 1 ☐ Yes  24a. Was an autopsy perform  1☐ Yes 2  Death (Check only one ng Home 5 ☒ Resider  28d. Describe how  28f. Location (Str. City or Town, one ng Home at the time, decourred at   | Month  acco use contribut  a 2 No 3  24b. Wen prior deat 1 1  nce 6 Other (i v injury occurred  weet and Number of State)  use(s) and mannete and place, and  | Day Year  te to the cause of death?  Probably 4 Unknowr e autopsy findings available t to completion of cause of th? Yes 2 No  Specify)  Transatranta Route Number, er as stated, due to the cause(s) |
| Affer this certificate has been signed by the attending physicia<br>uneral director, page 2 should be detached for use as the bur                          | edical Certification: To Be Completed by Physician/Medical | If any, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | equence of):  gnancy etal death f death  ER/Outpatien  28b. Time of Injury  chome, farm, structify)  anowledge, death ination and/or interest and the control of the contro | 26. Place of  26. Place of  27. Variety at Work?  M 1 Yes 2 No  28. Injury at Work?  M 1 Yes 2 No  29. License number  29. License number  | 1   Yes 2  24a. Was an autopsy perform   1   Yes 2  Death (Check only one   1   28d. Describe how   28f. Location (Str. City or Town,   1   28d. Describe how   28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. Location (Str. City or Town,    28f. | Month  acco use contribut  a 2 No 3  24b. Wer prior deat 1 0  nce 6 Other (3) w injury occurred  use(s) and manne the and place, and d. Date signed (No   | Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available t to completion of cause of th? Yes 2 No  Specify)  Transl Route Number, er as stated, due to the cause(s)       |

|  |                   | 1_ For State  | State of Maryla   | •                                  | partment of Fertificate of                                       |                         |                                 |                           | -                        | 2002                            | 11730  |
|--|-------------------|---|---|------------------------------------|--|-------------------------|---------------------------------|---------------------------|--------------------------|---------------------------------|--|
| 0 - 1  |                   | Registrar  1. Decedent's Name (First, Middle, La  | st)   | - 06                               | er linicate or   | Deau                    |                                 | ate of Dea                | Reg. No. (               | 2000                            | 3. Time of Death                                   |
| Physic<br>/Med   |                   | Margaret Mary Ba  | ,   |                                    |  |                         | Mai                             | onth<br>ch                | 14 Day                   | 2008                            | 2:15P <sup>M</sup>                                 |
| Exami  |                   | 4a. Facility Name (If not institution, giv  |   |                                    | 4b. City, Town, o  |                         | n of Death                      |                           |                          | County of Death                 |  |
| 3  |                   | Regency Nursing  5. Social Security Number 6.5  |   | rs. last birthday                  | Gambri   |                         | er 24 Hrs.   8. D               | ate of Birtl              |                          | Anne Arı                        | indel place (State or Foreign                      |
| Funeral<br>Director  | •                 |   | 100   | Yrs.                               | Months Days  | Hours                   | Min. (/                         | Month, $D_{\rm al}$       | y, Year)                 | Cou                             | ington, D.C.                                       |
| and<br>w   |                   | Usual Residence of Decedent  10a. State 10b. County   | 10c.  | City, Town or l                    | _ocation   |                         |                                 |                           |                          |                                 | 10d. Inside City Limits                            |
| Maryl<br>-f sho  | ţō                | Maryland Anne Arı   | ındel .   | Annapol                            | is   |                         |                                 |                           |                          |                                 | 1 <b>X</b> Yes 2 □ No                              |
| th the<br>or 28a<br>e noti   | Director          | 10e. Street and Number  |   |                                    | 10f. Zip Code  |                         |                                 |                           |                          | en of What Cou                  | ntry?  |
| s 23a  | ral               | 501 First Street  |   |                                    | 214  |                         |                                 | VN-                       |                          | JSA<br>4. Race - Ameri          | oon Indian   |
| Deficient (1975) Initially facing A 1 & 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at any once. | by Funeral        | 11. Marital Status  1 ☐ Never Married 2☐ Married 3 ☒ Widowed 4 ☐ Divorced   | 12. Was Decedent Ever in Armed Forces?  1 □Yes 2 ♣ No If Yes, Give Year or Dates: | 10.5.                              | B. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 2 No    |                         |                                 | res or No-<br>1, etc.)    |                          | Black, White                    |  |
| 72 ho  | Completed         | 15. Decedent's E<br>(Specify only highest gra   | ducation<br>ade completed)  | 16a. Dec                           | edent's Usual Occup<br>re kind of work done<br>DO NOT use retire | pation<br>during me     | ost of working                  |                           | 16b. Kind                | d of Business/li                | ndustry  |
| within<br>ene.<br>than '   | I du              | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                    | DO NOT use retire  | d)                      |                                 |                           |                          | artment                         | Store  |
| filed<br>i Hygi<br>other<br>ent, tl  | Be Co             | 17. Father's Name (First, Middle, Last  | )   |                                    |  | 18. Mot                 | her's Name (Fire                | st, Middle,               |                          |                                 |  |
| uld be<br>Wenta<br>Menta<br>irked  | To B              | William Farrell   |   |                                    |  | Katl                    | herine (                        | Cough                     | lin                      |                                 |  |
| VICITY INTO CITY  12 Should be filed within th and Mental Hygiene.  7 is marked other than traumatic event, the Me   | ľ                 | 19a. Informant's Name/Relationship ( Katherine B. Hill  | , Grand-  | 19b. Mai                           | iling Address (Street  | and Num                 | ber or Rural Ro                 | ute Numbe                 | er, City or              | Town, State, Zi                 | p Code)  |
| T and 2 Health tem 27 i  | L                 | 20a. Method of Disposition  | <u> </u>  | b. Place of Dist                   | 1 First Sposition (Name of                                       | i                       | t, Anna <u>r</u><br>Date        | polis                     |                          | 21403<br>ation - City or T      | own, State   |
| Pages 1 nent of H nt: If ite   |                   | 1  Burial 2  Cremation 3  4  Donation 5  Other (Speci   |   | cemetery, cr<br>ate of             | ematory or other pla<br>Heaven                                   | ice)                    | 3/20/20                         | 800                       | Silve                    | er Spri                         | ng, Maryland                                       |
| partilling permit. Pag Department Important: I any injury conce.   |                   | 21. Signature of Funeral Service Lice   |   | - 1                                | 22. Name and Addre   |                         |                                 |                           |                          |                                 |  |
| 0 83E 65   |                   | allent  |   |                                    | 16000 Ann  | -                       |                                 |                           |                          | Marylan                         |  |
|  |                   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final                             | one cause on each line.   | eath. Do not e                     | 1/   | ng, such a              | as cardiac or res               | piratory ar               | rrest,                   | Į.                              | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical  |                   | disease or condition resulting in death)  | a. On gell<br>Due to (or as a cons  | sequence of):                      | Hear   |                         | ailon                           |                           |                          |                                 | 2 years  |
| Examiner   | ١,                | Sequentially list conditions.   | b   |                                    |  |                         |                                 |                           |                          |                                 |  |
| ted<br>nsit  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a cons  | sequence of):                      |  |                         |                                 |                           |                          |                                 |  |
| be executed ician and burial-transit   | Exar              | that initiated events<br>resulting in death) Last   | C<br>Due to (or as a cons   | sequence of):                      |  |                         |                                 |                           |                          |                                 |  |
| cate be executed physician and the burial-transit  | dical             |   | d   |                                    |  |                         |                                 |                           |                          |                                 |  |
| The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the  | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf pre   |                                    |  |                         |                                 |                           | 23                       | 3d. Date of deliv               | /ery   |
| ie deatl<br>the atte   | sicia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 1 □ Live birth 2 □ F<br>4 □ Pregnant at time of<br>9 □ Unknown                    |                                    | B⊟Ectopic pregnand<br>i⊟ Other (s <i>pecify)</i> _               | у                       |                                 |                           |                          | Month                           | Day Year   |
| that thed the ed by detack   |                   | Part II. Other significant conditions   | contributing to death but not   | resulting in the                   | underlying cause giv   | ven in Par              | t 1.                            | 23e. Did to               | obacco us                | e contribute to                 | the cause of death?                                |
| w requires been signs should be  | d by              |   |   |                                    |  |                         |                                 | 1 🗆 🗅                     | Yes 2                    | 3 □ Pro                         | bably 4 □Unknown                                   |
| law re<br>as bee<br>2 sho  | Completed         |   |   |                                    |  |                         |                                 | 24a. Was<br>autop         |                          |                                 | opsy findings available ompletion of cause of      |
| The  | S                 |   |   |                                    |  |                         |                                 | perfo                     | rmed?<br>2 □ No          | death?<br>1 ☐ Yes               | 2 No   |
| SIcian<br>sertifi  | Be                | 25. Was case referred to medical examiner?  | Hospital: 1 ☐ Inpatient 2   | 2 ☐ ER/Outpati                     | out all pool Ott   | nor:                    | ce of Death (Ch                 |                           |                          |                                 | 1: 101   |
| g Phy<br>ter this<br>neral d   | n: To             | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year   | 28b. Time                          | of 28c. Inju   |                         | Nursing Home 28d.               | Describe h                |                          |                                 | Ingeri   |
| endin<br>eath.<br>or: Aff  | satio             | 1  Avatural 5  Pending 2  Accident investigatio 3  Suicide 6  Could not b   | n   |                                    | M 1  | Yes 2                   | □No                             |                           |                          |                                 | , .  |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s   | Certification:    | 3 ☐ Suicide 6 ☐ Could not be determined   |   | it home, farm, s<br>e <i>cify)</i> | street, factory, office  |                         | 28f. L                          | ocation (S<br>City or Tov | Street and<br>vn, State) | Number or Ru                    | ral Route Number,                                  |
| Hospit<br>24 hour<br>Funer<br>stely fill   | Medical           | 29a. Certifier 1 Certifying P. (Check only one)   | hysician: To the best of my<br>miner: On the basis of exam<br>and manner stated.  | knowledge, de<br>nination and/or   | ath occurred at the t<br>investigation, in my                    | ime, date<br>opinion, d | and place, and death occurred a | due to the<br>t the time, | cause(s) a<br>date and   | and manner as<br>place, and due | stated.<br>to the cause(s)                         |
| To the within To the comple  | Me                | 29b. Signature and title of certifier   | - // /-   | /                                  | 29c. Licen:  | se numbe                | r                               |                           | 29d. Date                | signed (Month                   | , Day, Year)                                       |
| 62   | C                 | * Wall  | horas   | m                                  | PZ   | -009                    | 4                               |                           | 3/2                      | 0/01                            |  |
| , D  | X                 | 30. Name and address of person who  | completed cause of death (  | Made                               | se fort  | - Why                   | ve Cla                          | - for                     | hie                      | Md, 2                           | 116/   |
| Si<br>Regis  | ate<br>trar       | 31. Date filed (Month, Day, Year)   | 32. Registrar's Si  |                                    |  |                         | 7                               |                           |                          | 7                               | (  |
| DHMH 17 Rev 1/   |                   | 12 G & 7140M  | 108 Blan  | S A                                | me   |                         |                                 |                           |                          |                                 |  |
|  |                   |   |   | 0                                  | RIGINAL  |                         |                                 |                           |                          |                                 |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 03 Z055M 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Ctr. Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 11/01/1939 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 167-30-2392 68 Pennsylvania Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 TYes 2 No Director Marvland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Sewall Court 21037 United States Completed by Funeral Pages 1 end 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Physics Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Michael Bachkosky, III Mary Hayko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen F. Bachkosky/Wife Sewall Court, Edgewater, Maryland 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 03/26/2008 | Edgewater, Maryland 21. Signature of head Signature Mcensee permit. 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -0100041 4095 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1∐ Yes or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospitai 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. nd title of certifier 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mutther J Malta (32 105 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State Registrar 26 2008

DHMH 17 Rev 1/2001

Oh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22, Dorothy Brazelton March 2008 12:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 1 □ M 2 🕱 F Months Days Hours Min. 81 293-20-1514 Mar. 02,1927 Ohio Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d, Inside City Limits MD Anne Arundel Arnold 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21012 256 Pendleton Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Claims Representative Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seba Stallings Roy Russell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Pendleton Court Arnold, Maryland 21012 Pamela B. Kanewske/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State March 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 2008 4 □ Donation 5 □ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Dart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Lunces disease or condition resulting in death) months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?
Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice 1 ☐ Yes 2**5** No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1.Da Natural 1 Tyes 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, or Attending Physician:

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural"

if Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical

Department of Important; If it any Injury or o

**Physician** 

/Medical

Examiner

burial-trai

attending physician for use as the buria

signed by the a

peen

death v

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

To the Funeral Director: After this completely filled in by the funeral dir To the Hospital within 24 hours a To the Funeral I Hospital Medical

> State Registrar

29a. Certifier

29b. Signature and title of centifier

and address of person who completed cause of death (Item 23a) (Type, Print) 1460 egistrar's Signati 6 2008

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 2008 **Physician** 1943 PM LE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMONE HOPKINS CH JOHNS Baltimore If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F 70 Director 577-48-9721 April 16, 1937 Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f show 1 ☐ Yes 2 ☑ No the Medical Examiner must be notified Director Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12006 St. Dunston Lane 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married P. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Associate Grocery Food Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h Be Pages 1 and 2 should be in ment of Health and Mental ျှ Robert M. Bel1 Mildred Durnbaugh Cangelosi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth C. Bell / Son 12006 St. Dunston Lane, Silver Spring, MD 20906 ace of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 3/31/2008 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Fun Jal Sorvice Licensee 2 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KESPINATURY do /Medical Due to (or as a consequence of) Examiner doys TROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LYPERTENSION 1 Yes No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 25 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA ٩ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 TYes 2 TNo 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

P.O. Box 68760. Division or Vital Records, To the Hospital or Attending 

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Woodus

GRAEME WOODWONTH

27 2008



600 N. WOLFE STREET

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

PACTIMONE , AD 2/287

29d. Date signed (Month, Day, Year)

MARCH 18, 2068

|          | 2508   |               | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  |  |
|----------|--|---------------|--|--|
| Dou      | glas Edward  |               | 1 For State  | 11743  |
|          | Physici  | لي            | Registrat 1 December Name (First Middle Last) 2. Date of Death 3.  | Time of Death                                |
| Med      | dical Exami  |               | er Douglas Edward Brown March 30, 2008   | 1058 hrs                                     |
| 1        |  |               | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Fort Washington  Fort Washington  Prince George's  |  |
|          |  |               | Put Washington Hospital Genter   | ace (State or Foreign                        |
|          | Funeral<br>Director  | - 1           | Months Doug Hours Min 7 7 44 40 FT County  | nington,DC                                   |
|          | Director   |               | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | illig coll, bo                               |
|          | u  | 1             | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10   | d. Inside City Limits                        |
|          | id<br>how s  | _             | Maryland Prince George's Upper Marlboro  | Yes 2 X No                                   |
|          | arylar<br>8a-fs  | Director      | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country  |  |
| $\wedge$ | the M<br>a or 2<br>tiffed  | Dir           | 8501 James Street 20772 United State   | PS .   |
| 4)       | ı with<br>ms 23<br>be no   | Funeral       | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.  | ı Indian, Black,                             |
| 1        | r deatl<br>or ite  | 표             | Never Married 2 Amarried 1 Yes 2 X No 1 Yes 2 X No Specify: White  | s  |
| 1        | is afte<br>iral",<br>miner   | by            | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: WD1 Te   |  |
|          | 2 hour<br>"nate  | ted           | during most of working life. DO NOT use retired)  Elementary/Secondary (ρ-32)  College (1-4 or 5+)  Locksmith  | i.   |
|          | 036<br>thin 7<br>ne.<br>r than<br>ledica   | Completed     | Locksmith private  |  |
|          | 5-0(<br>led wi<br>Hygien<br>other  | ပ္ပြ          | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Lillian Bell Bolen   |  |
|          | 121<br>d be fi<br>lental  <br>arked  | B B           | Description of the Court of the | in Code)                                     |
|          | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martla Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                   | 욘             | Carol Sue Brown -wife  196. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 8501 James Street Upper Marlboro, Marylan   | nd 20772                                     |
|          | and 2<br>and 2<br>Health<br>item 2<br>traum  |               | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To  | wn, State                                    |
|          | nord<br>ages l<br>nt of l<br>nt: If  |               | 1 K Burial 2 Cremation 3 Removal from State Resurrection Cemetery 4/4/2008 Clinton, Ma   | ərylənd                                      |
| ٨        | altin<br>nit. P<br>sartme<br>sortar  | 13            | 4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donald W. Borrowardt Funeral Home PA  |  |
| b        | E P P  | 8 8           |  | vland20705                                   |
|          | Physician<br>/Medical  |               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.  | Approximate Interval Between Onset and Death |
|          | xaminer  | 100           | Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):   |  |
| *        |  |               | h  |  |
|          |  | ner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause   |  |
|          |  | Examiner      | Ciscase or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |  |
|          | executed<br>an and<br>al - transit   | <u>~</u>      |  |  |
|          |  | dical         |  |  |
|          | Box 68760, a death certificate be the attending physic ed for use as the burn  | cian/Med      | FFEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da   | y Year                                       |
|          | c 68<br>certifi<br>ending<br>use as  | ciar          | past 12 months?    1   Live birth   2   Fetal death   3   Eccopic pregnancy   World   1   Day    | ž.   |
|          | Boy<br>death   | Physic        | 1 Yes 2 No 9 Unknown 9 Unknown   | of death 2                                   |
|          | P.O. es that the gened by ee detach  | by P          |  | bly 4 V Unknown                              |
|          | ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach.  | edb           | 24a. Was an 24b. Were auto   | ppsy findings available                      |
|          | Ord  IW req as bee   | plet          | 24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes   | mpletion of cause of                         |
|          | Rec<br>The licate l  | l e           | 1 ✓ Yes 2 No 1 ✓ Yes   | 2 No   |
|          | tal<br>cian:<br>certif   | Be            |  |  |
|          | of Vital Records, ng Physician: The law requir viter this certificate has been s meral director, page 2 should it  | 은             | O 1 Ves 2 No 28a Date of Injury 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred   |  |
|          | ion of V<br>tending Phy<br>eath.<br>tor: After the   | <u>ë</u>      | 1 X Natural 5 Pending (Month, Day, Year)   |  |
|          | Division 11 or Attendir 13 after ceath. 14 Director: A   | ertification: | To a coldent investigation 2 Accident Investigation 2 Suicide 6 Could not be 2 Se. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State)  | al Route Number, City                        |
|          | CiviSior  Hospital or Attend 24 hours after ceath 5 tuneral Director: etely fill d in by the   | er:           | 4 Homicide (Specify)   |  |
|          | <b>Division of Vital Records, P.O. Box 68760,</b> To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after ceath.  To the Funeral Director: After this certificate has been signed by the attending physici Ton the Funeral Energon: The fineral director, page 2 should be detached for use as the buri | <u>  2</u>    |  | t.<br>cause(s)                               |
|          | To the within To the comple  | Medical       | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b. Singature and title of certifier  29c. License number  29d. Date signed (Monitorial Control of the Con |  |
| 1        |  | ĮΣ            | 29b. Signature and title of certifier  29c. License number  O.C.M.E. OCME  March 31, 2008  |  |
|          |  |               | 30. Name and address of person who complet o cause of leath (Item 23a)   |  |
|          |  |               | Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   |  |
|          |  | State         | Look righted Cingonia  |  |
|          | Regi   | stra          | rar APK U ( 2000 ) Deplete St. 1990  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** March 27, Anna Jane Hoff Bailey 2:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Director 215-34-3535 69 May 17, 1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show t be notified at MD 1 ☐ Yes 2√ No Director Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5800-A Detrick Road 21771 USA r than "natural", or items 23a the Medical Examiner must Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Atlee Hoff Dorthine Myra Staub 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Dorthine Elizabeth Leach/daughter 5800-A Detrick Road Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Chesapeake Crematory 03/28/08 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner b Chronic Obstructive Pulmonary Disease Sequentially list conditions. It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit <sub>c</sub> Coronary Artery Disease and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical Dementia 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Ž∏ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}$  XOther (Specify) hospice Hospital: 1 Tes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending P hin 24 hours after death. the Funeral Director: After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

WQ\_

To the within 2

31. Date filed (Month, Day, Year) State MAR 2 8 Registrar

cause of death (Item 232) (Type, Print) alcolmalum, Wertminster MD 21157 32. Restrar's Signature 2008

and manner stated

29c. License number 1 - 00 54218

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Month Year Physician 2008 17:10 A. Patricia Faulk Britton March 20, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Waldorf 6019 Sirenia Place If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 Z F 1951 Moore County, NC Director March 9, 577-68-0069 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10h. County ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinar must be nutified at TXTYes 2 □ No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 6019 Sirenia Place 20603 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify <u>Ş</u> If Yes. Give Specify: Black 3 Widowed 4X Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event. 12 Accounting Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William D. McAllister Gladys Faulk ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6019 Sirenia Pl. Waldorf, Md. 20603 Albert B. Britton, lv / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/29/2008 Clinton, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice see 711085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC ADENOCARCINOMA OF SMALL INTESTING /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month Day Year 5 ☐ Other (specify) P.O. | ed by the a 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy page 1 □Yes 2 XNo 1 ☐Yes 2 ☐No certificate Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 🔁 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 120986 3-25-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(F)

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 6 2008

PISCATAWAY Rd CLINTON
Day, Year)
32. Hegistrar's Signature
6 2008

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** LHAUDRY USI 26 2008 /Medical 4c. County of Death **Examiner** Montgomary Hospital 1000ma 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. ocial Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 125-28-6547 Months Days Hours Pakistan Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Blud. 5893 20707 ed other than "natural", or items 23a event, the Medical Examiner must be 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Asian 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ord Blvd. Laurel Aleem y 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (New York Commercy, crematory of the place)
Maryland Mem Purk permit. Pages
Department of
Important: If It
any Injury or o Laurel 1 Burial 2 □ Cremation 3 □ Removal from State 3 26 08 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Aden Muslim Fun Services 21. Signature of Funeral Service Licensee 1242 En84 hille St. Woodbridge VA. 2219 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE MYELOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHEUMONIA ASPIRATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine EREMOVASCULAR ACCIDENT attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ANASMIA Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 COMPRESSION FRACTURES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 24a Was an autopsy 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Datient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Pate signed (Month, Day, Year) SHAMINI, WID D-59284

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 8 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHALLID SETAMIN,

WASHINGTON ADVENTUT HOSP TAKOMAPARK

3altimore, Maryland 21215-0036

death certificate be executed attending physician and for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar Ameno#'s16a.19b.PerFHPCC3-26-08cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03-15-2008 1:42 A M ARTHUR N. COURTNEY 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours 1 2 M 2 □ F 84 Chester, PA Director 208-12-0992 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene.
Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show many Injury or other traumatic event, the Medical Examiner must be notified at 1★ Yes 2 No Director Maryland Prince George's Suitland [ ] 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3051 Sunset Lane 20746 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: **Black** 3 Notice 3 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machnist Private Industry 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Mae Courtney Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3051 Sunset Land Arthur N. Harris/son Suitrand, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 03-21-08 1 ☐ Burial 2 图 Cremation 3 ☐ Removal from State Riverdale Pk.Crematory 4 □ Donation 5 □ Other (Specify) Riverdale, Maryland 21. Signature of Funeral Service Licensee

Many Hedgman 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, Maryland MO1374 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** taruti /Medical Due to (or as a consequence of): Examiner D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric MCDONAID MD 7503 SURRALLS Rd Clinton, md 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

| Physicial Medical Medi | al                   |   | NCIS CRA   | ·  |                                  |                                 |  |  |                                    |                 |  |                                  |
|--|----------------------|---|--|--|----------------------------------|---------------------------------|--|--|------------------------------------|-----------------|--|----------------------------------|
| Funeral<br>Director  |                      | 4a Encility Name //f  |  | NDALL  |                                  |                                 |  |  | 2. Date of De<br>March             | 25, Day         | 2008 <sup>Year</sup>                             | 3. Time of Death                 |
| Director   |                      |   |  | Hospital   |                                  |                                 | ib. City, Town, o<br>B <b>erlin</b>                      | Location of Death                                      |                                    | W               | County of Death Orcester                         |                                  |
| the Maryland<br>28a-f ehow   |                      | 5. Social Security No.  | 903  | DM 005   | (In yrs. last bir                |                                 | If Under 1 Year<br>Wonths Days                           | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Bi<br>Month D<br>08/26/ | 1938            | 9. Birth<br>Cou<br>New                           | place (State or Foreigntry) York |
| the M  | 2                    | Usual Residence of<br>10a. State  | 10b. County  |  | 10c. City, Tow                   |                                 |  | <del></del>  |                                    |                 |  | 10d. fnside City Limit           |
| 3a or  | Funeral Director     | MD 10e. Street and Num  | Worceste<br>Dar Stree                                      |  | Pocomo                           | же с                            | 10f. Zip Code<br>21851                                   |  |                                    | 10g. Citi       | zen of What Cou<br>USA                           |                                  |
| à <b>≗</b> ≅   | þ                    | 11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed   | ed 2 Married   | 12. Was Decedent E<br>Amed Forces?<br>1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates:  |                                  |                                 | s Decedent of H<br>'es, specify Cuba<br>Yes 2 XNo        | ispanic Origin? (Sp<br>nn, Mexican, Puerto<br>Specify: | pecify Yes or No Rican, etc.)      | 0-              | 14. Race - Ameri<br>Black, White<br>Specify: Whi | , etc.                           |
|  | Completed            | (Speci  | 15. Decedent's Ed<br>ify only highest gra-<br>ndary (0-12) | ucation<br>de completed)<br>Coflege (1-4or 5-  | +)                               | Deceder<br>(Give ki<br>life. DO |  | ation<br>during most of work<br>t)                     | king                               | 16b. Ki         | nd of Business/Ir                                | ndustry                          |
| laryland 212. 2 should be filled within and Mental Hygiene. le marked other then aumatic event, the M.   | Be                   | 17. Father's Name (   |  |  | Do                               | TESH                            | ian  | 18. Mother's Nam                                       |                                    | e, Maiden       |  |                                  |
| re, Maryland 212:<br>s 1 and 2 should be filed within<br>t Health and Mental Hygiens<br>item 27 is marked other then<br>other traumatic event, the M   | 1                    | 19a. Informant's Na<br>Nadine R   | me/Relationship (7   |  |                                  | •                               | •  | and Number or Rur                                      | al Route Numb                      | per, City o     |  |                                  |
| Baltimore, Misperit. Pages 1 and 2 Department of Health a important: If item 27 is eny injury or other tragons.  |                      | 20a. Method of Disp<br>1 Burial 2 5<br>4 Donation   |  | Removal from State   |                                  | ry, crema                       | ion (Name of<br>tory or other plac<br>Cremator           | (9)  | Date<br>/2008                      |                 | isbury,  | own, State<br>Md 21804           |
| 18760, crate be executed by physician and the burial-transit   | al Examiner          | Sequentially list cor<br>if any, leading to inc<br>cause. Enter Under<br>Cause (Disease or:<br>that initiated events<br>resulting in death) L | riying<br>injury   | с.   | a consequence                    | ,                               |  |  |                                    |                 |  |                                  |
| death certif   | by Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown Part II. Other signifi  | months?  | d.  23c. If yes, outcome of the control of the cont | 2 ☐ Fetal death<br>time of death | 5 🗆 (                           | ctopic pregnancy<br>Other (specify)<br>erlying cause giv |  | 23e. Did                           |                 | 23d. Date of deline Month                        | rery Day Year                    |
| of Vital Records, P.O. Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.   | Completed by         |   |  |  |                                  |                                 |  |  | 24a. Wa:<br>auto<br>perf           | opsy<br>formed? | 24b. Were aut<br>prior to co<br>death?           | opsy findings availal            |
| Division of Vital Records or attending Physician: The law requires effor death of the death of the confinence has been sign in by the funeral director, page 2 should be   | To Be                | 25. Was case referrexaminer? 1 Yes 2 2 27. Manner of Death 1 Natural  | No<br>1<br>5 □ Pending                                     | Hospital: 1 2 Inpatier<br>28a. Date of Injun<br>(Month, Day  |                                  | utpatient<br>Time of<br>Injury  | 28c. Injur<br>Wor  | y at k?  | th (Check only                     | idence          | 6 □Other (Spec                                   |                                  |
| Division or to the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral   | i Certification:     | 2 Accident 3 Suicide 4 Homicide   | investigation  6 Could not be determined                   | 28e. Pface of Injubulding, etc   | . (Specify)                      |                                 | t, factory, office                                       | Yes 2 □No  | City or To                         | wn, State       | ·)   | ral Route Number,                |
| To the Hospital within 24 hours of To the Funeral completely filled  | Medical              | 29a. Certifier<br>(Check only<br>one)<br>29b. Signature and   | 2 Medical Exam   | ysician: To the best of<br>iner: On the basis of<br>and manner stal  | examination an                   | e, death o                      | stigation, in my o                                       | pinion, death occur<br>e number                        | and due to the<br>red at the time  | , date and      | and manner as place, and due to signed (Month    | to the cause(s)                  |
| BA G   | te                   | 30. Name and address  | ea K t   | completed cause of de SALEY MY   | eath (Item 23a)                  | (Type, Pr                       | int)   | 36/2<br>way D  | r. Ber                             | 1,5             | MD 2   | 1811                             |

**Funeral** 

Director

show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has a state of the Arability of thems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at other traumatic event, the Medical Examinar must be notified at permit. Pages 1 a
Department of He:
Important: If Item
any Injury or othe

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed burial-trar attending physician for use as the burla ed by the a detached f certificate has been signed rector, page 2 should be det After this funeral Attending ours after death.
neral Director: A
filled in by the fu 9 To the Hospital of within 24 hours af To the Funeral D

P.O. Box 68760,

Division or Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<sup>Day</sup> Mar. 2008<sup>ai</sup> Bernadine Mary Crutchley 10:58 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Linthicum Anne Arundel Tate Hospice House 8. Date of Birth Month, Day, Year 924 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 M XXF MaryTand 83 217-16-4847 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XX es 2 □ No Anne Arundel Director MD Annapolis 4 8 1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 730 Glenwood Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣12.No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank A. Pilarski Frances Marski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Wilson Crutchley 730 Glenwood Street Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 3/26/08 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue Annapolis, MD 21401 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 252500015419disease or condition resulting in death) in Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 550 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

Registrar

MAR 2

6 2008

|                            |  |                     | For<br>State<br>Registrar   | State of Marylan  |                             | artment of F  |                               | •  | giene<br>Reg. No.                    | 8 11750   |
|----------------------------|--|---------------------|---|---|-----------------------------|---|-------------------------------|--|--------------------------------------|---|
| Ŷ.                         | Dhuaiai  |                     | Decedent's Name (First, Middle, La  | rst)  |                             |   |                               | 2. Date of De                            | eath                                 | 3. Time of Death  |
|                            | Physician  /Medical  Syamilor  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  |                     |   |   |                             |   |                               | March                                    | 22, 2008                             |   |
| i                          | Examin   | er                  | 4a. Facility Name (If not institution, given Frederick Memor  | ,   | n                           | 4c. County of De  |                               |  |                                      |   |
|                            | Funeral  |                     |   | Sex 7. Age (In yrs.   | • • •                       | if Under 1 Year<br>Months Days                                | If Under 24 Hrs<br>Hours Min. |  | rth 9. E                             | Birthplace (State or Foreign<br>Country)  |
|                            | Director   |                     | 578-50-7384 Usual Residence of Decedent   | 92  | Yrs.                        |   |                               | March 3                                  | 30, 1915 Wa                          | shington, DC  |
|                            | yland<br>how<br>at   |                     | 10a. State 10b. County  | 10c. City   | y, Town or Lo               | cation  |                               |  |                                      | 10d. Inside City Limits   |
|                            | Ba-f s   | ctor                |   | oucester  | Ha                          | yes   |                               |  |                                      | 1 □ Yes 2 🛣 No  |
|                            | with the a or 2 the no   | Dir                 | 10e. Street and Number<br>1981 Tillage La   | ane   |                             | 10f. Zip Code<br>23   | 072                           |  | 10g. Citizen of What USA             | Country?  |
|                            | death  | nera                | 11. Marital Status  | 12. Was Decedent Ever in U.<br>Armed Forces?  | S. 13.                      | Was Decedent of H<br>If Yes, specify Cub                      | tispanic Origin? (S           | Specify Yes or No                        | 14. Race - Ar<br>Black, W            | merican Indian,   |
| 036                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 15 Widowed 4 ☐ Divorced   | 1 Tyes 2 No If Yes, Give Year or Dates:   |                             | 1 ☐ Yes 2 <sup>1</sup> No                                     | Specify:                      | to ritidan, etc.)                        | Specify: Wh                          |   |
| 21215-0036                 | iin 72 ho<br>n "natui<br>Medical   | Completed           | 15. Decedent's E<br>(Specify only highest gi  | ducation<br>ade completed)  College (1-4or 5+)  | (Give                       | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of wo             | rking                                    | 16b. Kind of Busines                 | ss/Industry   |
| 212                        | ed with<br>ygiene<br>ter tha   | Com                 |   | 4   | Pe                          | rsonnel   |                               |  |                                      | Government  |
| Maryland                   | d be file<br>ental H<br>ked oth<br>c even  | Be                  | 17. Father's Name (First, Middle, Las Francis I. Cahil  | *   |                             |   |                               | <sup>me (First, Middle</sup><br>Kauffman | , Maiden Surname)                    |   |
| aryl                       | shoul<br>and Me<br>s mark  | 2                   | 19a. Informant's Name/Relationship  | (Type. Print)   | 19b. Mailir                 | ng Address (Street  | and Number or R               | ural Route Numb                          | per, City or Town, State             | e, Zip Code)  |
|                            | and 2<br>lealth a<br>m 27 l  |                     | Barbara A. Tillma   |   | Name of Disco               |   | lage Lan                      |  | , Virginia                           |   |
| Baltimore,                 | Pages 1<br>nent of F<br>ant: If Ite<br>ury or ot   |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 🖾 Other (Spec                        | Removal from State  | emetery, crei               | esition (Name of<br>matory or other place<br>Heaven           |                               | rch 26,<br>2008                          | 20c. Location - City Silve           | er Spring, MD   |
| Balt                       | permit. Departr Importa any inj  |                     | 21. Signature of Funeral Service Lice   | ensee   |                             |   |                               |  | l Home Inc                           | ing, MD 20901   |
| E                          | 5.5  |                     | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only                                 | nplications that cause he deat  |                             |   |                               |  |                                      | Approximate<br>Interval Between   |
|                            | Physician  |                     | Immediate Cause (Final disease or condition resulting in death)   |   |                             | PONIA   |                               |  |                                      | Onset and Death  DP 75  |
|                            | /Medical<br>Examiner   |                     | 1   | Due to (or as a conseq  |                             | RE  | NAI                           | FAIL                                     | NR E                                 | DAYS  |
|                            | <b>1</b>   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a conseq   |                             | , .   | , , , ,                       | , ,,,,                                   |                                      |   |
|                            | ecuter<br>and<br>Frans   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last                                     | c<br>Due to (or as a conseq   | nence of).                  |   |                               |  |                                      |   |
| 8760,                      | icate be executed<br>physician and<br>s the burial-transit   | dical E             |   | d.  | 00/100 01/.                 |   |                               |  |                                      |   |
| 9                          |  | Medi                | IF FEMALE:  |   |                             |   |                               |  |                                      |   |
| O. Box                     | The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as  | Physician/Me        | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No   | 23c. If yes, outcome pf pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown | Ideath 3                    | □Ectopic pregnanc<br>□ Other (specify) _                      | У                             |  | 23d. Date of<br>Month                | delivery<br>Day Year  |
| , P.O.                     | ires that ti<br>signed by<br>I be detac  | by Ph               | Part II. Other significant conditions   | contributing to death but not res   | ulting in the u             | nderlying cause giv   | ren in Part I.                | 23e. Did                                 | tobacco use contribute               | e to the cause of death?  |
| Srds                       | w require<br>been sig<br>should b  | ed b                |   |   |                             |   |                               | 10                                       | Yes 2 No 3 □                         | Probably 4 Donknown   |
| Division or Vital Records, | The law r<br>tte has be<br>vage 2 sh   | Completed           |   |   |                             |   |                               | 24a. Was<br>auto<br>perf<br>1∐ Yes       | opsy prior death                     | autopsy findings available<br>to completion of cause of<br>?<br>es 2 \square No |
| /ital                      |  | Be C                | 25. Was case referred to medical examiner?  |   |                             | la.   |                               | ath (Check only                          |                                      |   |
| or/                        | Physician:<br>r this certifica<br>ral director, I  | 은                   | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | Hospital: 1 Inpatient 2   28a. Date of Injury   | ER/Outpatier<br>28b. Time o | " JU BOX  |                               | T  | idence 6 Other (S                    | pecify)   |
| ion                        | Attending<br>r death.<br>ector: After<br>by the fune   | ation               | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | (Month, Day Year)   | Injury                      | Wo  | rk?<br>Yes 2 ∐ No             | Zod. Bodonibo                            | now injury occurred                  |   |
| Divis                      | l or Atte<br>after des<br>Directo  | Certification:      | 3 ☐ Suicide 6 ☐ Could not l<br>4 ☐ Homicide determined  |   |                             | reet, factory, office   |                               |  | (Street and Number or<br>own, State) | Rural Route Number,   |
| _                          | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Medical C           | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa  | hysician: To the best of my kno<br>aminer: On the basis of examina<br>and manner stated.              | tion and/or in              | vestigation, in my  | opinion, death occ            | urred at the time                        | date and place, and                  | due to the cause(s)   |
|                            | To th<br>withir<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier   | ,   |                             | 29c. Licens   | se number                     |  | 29d. Date signed (Me                 | onth, Day, Year)  |
|                            | 3  |                     | Mhl   | ms  |                             | 200   | 61410                         | 2  | MARCH,                               | 23, 2008  |
|                            |  |                     | 30. Name and address of person who  | completed cause of death (Iten  | 23a) (Type,                 | Print)  | 400                           | WEST                                     | 7 46 574                             | onth, Day, Year)  23 , 2008  REDERICK, M.  REET 21701                           |
|                            | Sta  | ite                 | 31. Date filed (Month, Day, Year)   | 32. gistrar's Signa   | ature                       | P M   | , , , ,                       |  |                                      | 21101   |
|                            | Registi  | ar                  | MAR 27  | 2008 Been 1   | 15. A                       |   |                               |  |                                      |   |

DHMH 17 Rev 1/2001

|                |   |               | 1 - State of Maryland / Dep   | artment of Health and ertificate of Death   |  | ene<br>g. No. 2008                           | 11751                           |
|----------------|---|---------------|---|---|--|--|---------------------------------|
|                | Db:   |               | 1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                                 |  | 3. Time of Death                |
|                | Physici<br>/Medic   |               | Phillip Nathaniel Carter  |   | Month<br>March 19                                | Day Year 2008                                | 5:00pm M                        |
| m.             | Examin  |               | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Deat   |  | 4c. County of Deat                           | h                               |
| 1              |   |               | 7 Laughton Street   | Upper Marlboro  |  | Prince Ge                                    | orge's                          |
|                | Funeral   |               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday  | If Under 1 Year   If Under 24 Hrs   |  |  | hplace (State or Foreign        |
|                | Director  |               | 577 <b>-</b> 54-8048  | Months Days Hours Min.  |  |  | ington, D.C.                    |
|                | p.  |               | Usual Residence of Decedent   |   | 11127 2.73                                       | LJAU Wash                                    |                                 |
|                | show  | _             | 10a. State 10b. County 10c. City, Town or L   | ocation   |  |  | 10d. Inside City Limits         |
|                | e Ma  | 9             | Maryland Prince George's Upper Mar  | 1boro   |  | i  | 12⊈Yes 2 ☐ No                   |
|                | th th   | Director      | 10e. Street and Number  | 10f. Zip Code   | 10   | g. Citizen of What Co                        | untry?                          |
|                | th wi   |               | 7 Laughton Street   | 20774   | TT.  | nited Stat                                   | 0.0                             |
|                | dea   | Funeral       |   | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puer   | Specify Yes or No-                               | 14. Race - Ame                               | rican Indian,                   |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitizat round be notified at once. | by Fu         | 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:   | 1 ☐ Yes 2 ☑ No Specify:   | to nican, etc.)                                  | Black, White Specify: B1a                    |                                 |
| ŏ              | hou stura   | be            | 15. Decedent's Education 16a. Dece  | edent's Usual Occupation  | 11   | 6b. Kind of Business/I                       | ndustry                         |
| 15             | in 72<br>n "na<br>n "na   | Completed     | (Specify only highest grade completed) (Give  | e kind of work done during most of wor<br>DO NOT use retired)   | rking  | ob. Kind of Business/i                       | ridusti y                       |
| 212            | i with  | E O           | College (1-4or 5+)  | visor Train Opera   |  | Government                                   |                                 |
|                | filed<br>I Hyg<br>othe<br>ent,  | Be C          | 17. Father's Name (First, Middle, Last)   |   | me (First, Middle, Ma                            |  | <del></del>                     |
| lan            | d be<br>enta<br>ked d   | 70 B          | Charles Wilbur Carter   | 26  |  |  |                                 |
| 5              | mari  | F             |   | <u>  Marquer1</u><br>ing Address (Street and Number or Ri   | te Carter  | City or Town State 7                         | in Cada)                        |
| Maryland       | id 2 s<br>ith ai<br>27 is<br>1 trau   |               |   | ghton St. Upper M   | •  | , , , , , , , ,                              | ip Code)                        |
| ð,             | 1 ar<br>Hea<br><b>Fern</b> 3  |               | 20a. Method of Disposition 20b. Place of Disp   |   |  | MG • ZU / / 4<br>Dc. Location - City or T    | Town State                      |
| ē              | Pages nent of hant. If ite  |               | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State   | matory or other place)  |  | oc. Econion Only of                          | own, otate                      |
| ≣              | rtan<br>rtan<br>njury   |               | 4□Donation 5□Other (Specify) Fort Linc  | oln 3/26  | /2008 B  | rentwood,                                    | Md.                             |
| Baltimore,     | perm<br>Depa<br>Impo<br>any i   |               | 21. Signature Funeral Service Licensee 2  | 2. Name and Address of Facility Po  | pe Funera  | 1 Homes, P                                   | .A.                             |
|                | 40 2 0 0  |               | 10 minous 12  | <u>538 Marlboro Pike</u>  | Forestvi   | 11e, Md. 2                                   | 0747                            |
|                |   |               | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en<br>shock, or heart failure. List only one cause on each line. | ter the mode of dying, such as cardia   | c or respiratory arres                           | st,  | Approximate<br>Interval Between |
| Car.           | Physician   |               | Immediate Cause (Final disease or condition a KIDNEY CANCER   |   |  |  | Onset and Death                 |
| 1              | /Medical  |               | resulting in death)  Due to (or as a consequence of):   |   |  |  |                                 |
|                | Examiner  |               | Sequentially list conditions b.   |   |  |  |                                 |
|                | დ .⊨  | Examiner      | Sequentially list conditions, if any, leading to immediate cause. Find III any Cause (Disease or injury.  |   |  |  |                                 |
|                | ecute<br>nd<br>trans  | am            | triat initiated events C  |   |  |  |                                 |
| oʻ             | e exe<br>ian a<br>ırial-i   |               | resulting in death) Last Due to (or as a consequence of):   |   |  |  |                                 |
| 68760,         | ificate be executed<br>g physician and<br>is the burlal-transit   | edical        | d   |   |  |  |                                 |
| 99             |   | led           | IS SERVICE.   |   |  |  |                                 |
| Box            | The law requires that the death certifi<br>site has been signed by the attending<br>bage 2 should be detached for use as  | Physician/M   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3  | ☐ Ectopic pregnancy   |  | 23d. Date of deli                            | very                            |
| О. Е           | dea<br>ne atf   | <u>i</u>      | 1 Yes 2 No 4 Pregnant at time of death 5  | Other (specify)   |  | Month  | Day Year                        |
| P. 0           | at the de<br>by the<br>tached   | hys           | 9 ☐ Unknown   |   |  |  |                                 |
| ·ń             | s tha   | β             | Part II. Other significant conditions contributing to death but not resulting in the u  | inderlying cause given in Part I.   | 23e. Did toba                                    | cco use contribute to                        | the cause of death?             |
| Vital Records, | w requires that<br>s been signed t<br>should be deta  |               |   |   | 1 ☐ Yes  | 2 ☐ No 3 ☐ Pro                               | obably 4 🖰 Unknown              |
| ပ္ပ            | w re  | Completed     |   |   | 24a. Was an                                      | 24h Ware aut                                 | opsy findings available         |
| 8              | The lar   | Į,            |   |   | autopsy  | prior to c                                   | ompletion of cause of           |
|                |   |               | 25. Was case referred to medical  |   | 1 □ Yes 2  |  | 2 🖾 No                          |
|                |   | Be            | examiner? Hospital:   | Othorn  | ath (Check only one)                             |  |                                 |
| o              | Phys<br>rathis  | e<br>E        | 1 ☐ Yes 2 ☑ No ☐ I ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death   | 11 3 DOA 4 Nursing H  |  | ce 6 Other (Spec                             | rify)                           |
| ב              | ding Ph<br>h.<br>After th<br>funeral  | <u>i</u>      | 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury   | Work?   | 28d. Describe how                                | injury occurred                              |                                 |
| S              | tten<br>deat<br>tor:<br>the   | cat           | 2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home form at  | M   1 □ Yes 2 □ No  |  |  |                                 |
| Division of    | or A<br>after<br>Direc<br>in by   | ertification: | 4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)  | eet, factory, office  | 28f. Location (Stre<br>City or Town,             | et and Number or Rui<br>State)               | ral Route Number,               |
| _              | pital<br>ours a<br>eral I   | OL            | 29a, Certifier Certifying Physician: To the best of my knowledge, deat  | the appropriate that the state of the state |  |  |                                 |
|                | To the Hospital or Attending P within 24 hours after death.  To the Funeral Director. After t completely filled in by the funeral   | edical        | 29a. Certifier (Check only one)  Check only one)  (Check only one)  Check only one)  (Check only one)  (Check only one)                         | in occurred at the time, date and place<br>evestigation, in my opinion, death occu  | e, and due to the cau<br>urred at the time, date | use(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)      |
|                | To the within 2 To the complet  | ğ             | 295. Signature and title of certifier   | 29c. License number   | 290  | I. Date signed (Month                        | , Day, Year)                    |
| h              |   |               | havam O. Welltza  | D23743  | Ma   | arch 21, 20                                  | 800                             |
|                | (E)   | -             | 30. Name and address of person who completed cause of death (Item 23a) (Type,   |   |  |  |                                 |
| _              | 0/  |               | Martin Weltz, MD 7525 Greenway Ctr. Dr  |   | 1. 20770   |  |                                 |
|                | Stat  | е             | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |   |  |  |                                 |
|                | Registra  |               | 31. Date filed (Month, Day, Year)  MAR 2 6 2008  Security 32. Registrar's Signature  A provider   |   |  |  |                                 |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) March 23, 2008 Year **Physician** April Denise Fenwick Dixon 5:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Mary Land 1 □ M 2 1 F 217-72-8461 45 1962 Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Directo Maryland | Prince George's Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or: any injury or other traumatic event, the Medical Examiner must be n 4215 72nd Avenue 20784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Program Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Marshall Fenwick Queenie Jeannette Barnes ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harvey Dixon 4215 72nd Avenue, Landover Hills, MD 20784 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Chesapeake Crematory 3/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Sanatur o Funeral Service Licens 22. Name and Address of Facility Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Leukemi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying vause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Patural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? after death. 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital within 24 hours at To the Funeral D

State Registrar

Medical

29a. Certifier

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 Hospital Dr. Chevely lice 20185 M.D.

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

MAR 2 8 2008

29b. Signature, and title of certifier

32. Registrar's Signature

|  |                      | State of Maryland / Department of Health and N  1- State Registrer Certificate of Death  |                                 | giene                         | 08   1753  |
|--|----------------------|--|---------------------------------|-------------------------------|--|
| Physicia<br>/Medica  | n<br>al              | 1. Decedent's Name (First, Middle, Last)  Claudine Dublin Dunn   | 2. Date of De<br>Month<br>ARCIH | Day 2                         | Year 3. Time of Death 9.40 PM  |
| Examine  |                      | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Holy Cross Rehabilitation & Nursing Center Burtonsvi  5. Social Security Number  6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.  | 11e                             | th                            | of Death  Itgomery  9. Birthplace (State or Foreign                              |
| Funeral<br>Director  |                      | 578-24-6478 1 □ M 2 X F 91 Yrs. Months Days Hours Min.  Usual Residence of Decedent  | (Month, Da                      | 14,1916                       | Maryland   |
| Ba-f ehow  | Director             | 10a. State     10b. County     10c. City, Town or Location       Maryland     Montgomery     Burtonsville  |                                 |                               | 10d. Inside City Limits  1  Yes 2 □ No   |
| th with th   | ai Dir               | 10e. Street and Number         10f. Zip Code           3415 Greencast1e Road         20866   |                                 | 10g. Citizen of V             | States   |
| SI J   | Completed by Funeral | 11. Marital Status    1  | ,                               | Specify 16b. Kind of Bu       | a- American Indian, k, White, etc. : Black :siness/Industry                      |
| 0 7 5  | Be Cor               |  | ,                               | , Maiden Sumam                | е)   |
| and 2 should<br>lealth and Men<br>m 27 is marke<br>her traumatic                                   | ဥ                    | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  Eola Claudine Baskin (Daughter)  5711 Heritage Hill Co  | ourt;Ale                        | xandria,                      | State, Zip Code) 22310   |
| permit. Pages 1 ar<br>Department of Hea<br>Important: if item:<br>eny injury or other              |                      | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21 Ignature of Juneral Sance License.  22 Name and Address of Facility R. N. Horton Compa  | ny Mort                         | Suitlan                       | d, Maryland Inc.   |
| ate be<br>nysicie  | lical Examiner       | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fairy, leading to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  | or respiratory a                | rrest,                        | Approximate<br>Interval Between<br>Onset and Death                               |
| death<br>e atter   | Physician/Med        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 MNo 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   5   Other (speci |                                 | 23d. Dat                      | e of delivery<br>nth Day Year  |
| es the   | ۾                    | Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                 | tobacco use contr<br>Yes 2 No | ribute to the cause of death?  |
| The page   | Completed            | 25. Was case referred to medical 26. Place of Dea  | 1□ Yes                          | 2 No 1                        | Nere autopsy findings available prior to completion of cause of leath?  Yes 2 No |
| this al did  | ation: To Be         | examiner?  | lome 5 ☐ Resi                   | one) dence 6 Oth              |  |
| itel or Attending Phy<br>urs after death.<br>rrai Dirsctor: After this<br>lled in by the funeral d | Certification        | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | City or To                      | wn, State)                    | er or Rural Route Number,  |
| To the Hospitel or A within 24 hours after To the Funeral Dire completely illied in b              | Medical              | 29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number  | rred at the time,               | 29d. Date signed              | and due to the cause(s)  1 (Month, Day, Year)                                    |
| Stat   |                      | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Suite                           | 283 P.                        | ACR MD 2120  |
| Registra   | ir i                 | MAR 2 8 2008 France & Species  |                                 |                               |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Much 2003 Kenneth R. Donnelly, 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 160 Hollingsworth Manor E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | April 21, 1947 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **3** M 2 □ F Yrs. 60 Director 138-36-3857 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MD Ceci1 Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e ns 23a must b 160 Hollingsworth Manor 21921 Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status "natural", or Item 1 ☐ Never Married 2 ☑ Married tyDYes 2□No If Yes, Give Year or Dates: 1960 's Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Medical Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental Hem 27 is marked out ther traumatic ever Edward T. Donnelly, Sr. Beth Kears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other trong once. Charlotte Donnelly/Wife 160 Hollingsworth Manor, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State April 2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ferris Inc. 4 ☐ Donation 5 ☐ Other (Specify) West Chester, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed MI Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ading p. IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy 1∐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: after death. filled in by within 24 hours af

To the Funeral D

completely filled i the Hospital

mees NA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wet mais HSU MP CHIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 27/08

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

| Physician |
|-----------|
|           |
| /Medical  |
| Examiner  |
|           |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other trsumatic event, the Medical Exa<u>miner must be notified at</u>

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed oue runeral birector; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran within 24 hours after death.

To the Funeral Director: After this certificate has been

Division or Vital Records, P.O. Box 68760,

|   | 1 - State Registrar   | Cei  | rtificate of L  |                                   |  | g. No.  | 700   | 11100  |  |  |
|---|---|--|---|-----------------------------------|--|---|---|--|--|--|
| an :                                    | 1. Decedent's Name (First, Middle, Last)  Stewart   |  | Duva1   |                                   | 2. Date of Death<br>Month<br>March 22        |   | Year  | 3. Time of Death 1945 M                                  |  |  |
| al<br>er                                | 4a. Facility Name (If not institution, give street and number, 162 Southdown Road   | )  | 4b. City, Town, or Edgewate   |                                   | L  | 4c. County  | y of Death                                      | del  |  |  |
|   | 5. Social Security Number 6. Sex 7. An 578-22-3748 ★★ 2□ F  | ge (In <i>yrs. last birthday</i> )<br>86 Yrs.      | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.    | 8. Date of Birth (Month, Day) 7/26/19        | Year)<br>21   | 9. Birthp<br>Cour                               | nlace (State or Foreign<br>ntry)<br>TX                   |  |  |
| tor                                     | Usual Residence of Decedent  10a. State   | 10c. City, Town or Lo                              | ocation<br>Water  |                                   |  |   | 1   | 0d. Inside City Limits                                   |  |  |
| al Direc                                | 10e. Street and Number<br>162 Southdown RD.   |  | 10f. Zip Code   | 21037                             | 10   | g. Citizen of   | What Cour                                       | ntry?  |  |  |
| To Be Completed by Funeral Director     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ∰Widowed 4 □ Divorced  1 □ Was Decedent Armed Forces:  1 □ Yes 2 □ If Yes, Give Year or Dates: | No WWII  | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                                      | an Indian,<br>etc.<br>nite        |  |   |   |  |  |  |
| omplete                                 | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 4                                      | 5+) (Give life.                                    | dent's Usual Occupa<br>kind of work done a<br>DO NOT use retired,                                 | ation<br>luring most of work<br>) | king   |   | Kind of Business/Industry                       |  |  |  |
| To Be C                                 | 17. Father's Name (First, Middle, Last)  Claiborne A. Duval   |  |   | Hazel S                           |  |   |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type. Print) Joe Duval Son  | 34 H   | ng Address (Street a  | . Edgewa                          | ater, MD                                     | 21037   |   |  |  |  |
|   | 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | Metro Cre  | matory or other place<br>ematory  | 3/26/                             |  | altimo  | •   |  |  |  |
|   | 21. Signature of Funeral Service Licensee   | 2  | 2. Name and Addres<br>Hardesty  | ss of Facility Funeral 1          | Home P.A.                                    | 12 Ri   | idgely  | y AvelANN,M  |  |  |
|   | resulting in death)   | ine.   | RREST   | •                                 |  | st,   |   | Approximate Interval Between Onset and Death             |  |  |
| Completed by Physician/Medical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | s a consequence of):                               |   |                                   |  |   |   |  |  |  |
| ysician/Me                              |   | 2 Fetal death 3                                    | ⊒Ectopic pregnancy<br>⊒ Other <i>(specify)</i>  |                                   |  | 23d. Date of delivery  Month Day Year   |   |  |  |  |
| ed by Pr                                | Part II. Other significant conditions contributing to death   | but not resulting in the u                         | underlying cause give   | en in Part I.                     | 23e. Did tob<br>1 ☐ Ye                       | id tobacco use contribute to the cause of death?  ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown |   |  |  |  |
| Complet                                 |   |  |   |                                   | 24a. Was ar<br>autops<br>perforn<br>1∐ Yes 2 | /   | . Were auto<br>prior to co<br>death?<br>1 ☐ Yes | ppsy findings available<br>mpletion of cause of<br>2□ No |  |  |
| To Be                                   | 25. Was case referred to medical examiner?  1  Yes  2 No  Hospital: 1   Inpat   | ient 2 ☐ ER/Outpatie                               |   | er: 4 🗆 Nursing H                 | th (Check only one one 5X Reside             |   | her <i>(Sp</i> ecii                             | (y)  |  |  |
| ation:                                  | 27. Manner of Death  1 Natural 5 Pending (Month, D  |  | of 28c. Injury at 28d. Describe how injury occurred   |                                   |  |   |   |  |  |  |
| Medical Certification:                  | 4 Homicide determined building, e   | njury - At home, farm, st<br>etc. <i>(Specify)</i> | street, factory, office  28f. Location (Street and Number or Rural Route Num City or Town, State) |                                   |  |   |   |  |  |  |
| ledical                                 | 29a. Certifler (Check only one)  CertifyIng Physician: To the bes 2 Medical Examiner: On the basis and manner s                                     | of examination and/or ir                           | nvestigation, in my o   | pinion, death occu                | rred at the time, da                         | ate and place   | , and due t                                     | o the cause(s)   |  |  |
| Σ                                       | 29b. Signature and title of certifier   | Ø7.  | 29c. License number 29d. Date signed (Month, Day, Year) 3 - 2 4 - 2008                            |                                   |  |   |   |  |  |  |
|   | 30. Name and address of person who completed cause of \$88 BESTOATE ROAD  | death (Item 23a) (Type,                            | Print) Loul.  | S K E                             | CISANI                                       | MD,   | NO<br>2   | 1401   |  |  |

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 2 6 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** J. Donaldson March 22, 2008 12:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☐ M 2 🔀 F 249-74-8599 Director 65 July 17, 1942 South Carolina Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified at 1- Yes 2 No Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 557 Wilson Bridge Drive 20745 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Merital Hygiene. Important: If item 27 is marked other thermany injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 25 Married African 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vear LPN Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Houser Boseman Maritha Rice 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Donaldson, Jr. - Husband 557 Wilson Bridge Drive Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gethsemane Ch. Cemt. Mar 29, 2008 Greenville, S.C. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service I 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ac Kes porton **Physician** railwe /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 88 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1□ Yes I or Attending Physician: after death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) March 22 2008 D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern avenue SE Sucte 310 Washington DC 20032 MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

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| Division or Vital Records, P.O. Box 68760,   |                  | Baltimore, Maryland 21215-0036   |
|--|------------------|--|
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | Phy<br>/M<br>Exa | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. |
| To the Funeral Director: After this certificate has been signed by the attending physician and                               | sic<br>ed<br>m   | Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show   |
| completely filled in by the funeral director, page 2 should be detached for use as the burial-transit                        | 3                | any injury or other traumatic event, the Medical Examiner must be notified at  |
|  |                  |  |

Funeral Director

| ın  | 1. Decedent's Name   | (First, Middl  | le, Last)   |  |  |  |  | 2. Date of De-<br>Month  | ath<br>Day   | Year   |   |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|---|--|--|--|
| al  |  |  | ECKSTORM,   |  |  | # 00 T   |  | MARCH  | 25   | 2008   | 12:35 I   |  |  |  |
| er  | 4a. Facility Name (If r  |  |   |  | COIDM  | 4b. City, Town, or I   |  | ٦  |  | ity of Death   | re I c  |  |  |  |
|   | 5. Social Security Nur   |  | FOR QUEEN 6. Sex  | 7. Age (In yrs.  |  | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birt  | h  | 9. Birthp  | place (State or For   |  |  |  |
|   | 216-14-93  | 65   | 1 <b>X</b> M 2□ F   | 85   | Yrs.   | Months Days  | Hours Min.   | (Month, Da   |  | MAR  | YLAND   |  |  |  |
|   | Usual Residence of D   | Decedent<br>10b. County  | ,   | 10c. Cit   | ty, Town or Lo   | cation   |  |  |  | 1  | 0d. Inside City Lir   |  |  |  |
| 후   | MARYLAND   |  | N ANNE'S  |  | STEVENS  | VII.I.E  |  | 1 □Yes   |  |  |   |  |  |  |
| Director  | 10e. Street and Numb   |  | THUILD D  |  | 3 2 2 3 3 3 2 3 2 3 2 3 2 3 2 3 2 3 2 3  | 10f. Zip Code  |  |  | 10g. Citizen of What Country?  |  |   |  |  |  |
|   | 618 LOVE   | POINT  | ROAD  |  |  |  | 1666   |  |  | D STA  |   |  |  |  |
| Funeral   | 11. Marital Status   | d 2457 Mor   | Armed Fo  |  | J.S. 13.   | Was Decedent of His<br>f Yes, specify Cubar  | spanic Origin? (S<br>n, Mexican, Puert   | pecify Yes or No<br>o Rican, etc.)   | pecify Yes or No-<br>D Rican, etc.) 14. Race - American Indian,<br>Black, White, etc.  |  |   |  |  |  |
| ğ   | 1 ☐ Never Married 3 ☐ Widowed 4  |  | If Van Cit  | ve<br>ates: <b>1942</b> —  | 1946   | 1 ☐ Yes 2 🛣 No   | Specify:   | Specify: WHITE   |  |  |   |  |  |  |
| sted  | (Specifi   | 15. Deceder  | nt's Education<br>est grade completed)  |  | 16a. Deced   | dent's Usual Occupa<br>kind of work done di  |  | rkina  | dustry   |  |   |  |  |  |
| Completed   | Elementary/Second  |  | College (1  | I-4or 5+)  | ilife. I   | DO NOT use retired)  | · ·  | 9  |  | TUTTOR   | OTD CTIVE   |  |  |  |
|   | 17. Father's Name (F   | irst Middle  | l ast)  |  | <u> </u>   | OLICE OFF  |  | ne (First, Middle  | LAW ENFORCEMENT  |  |   |  |  |  |
| To Be   | ,  |  | CKSTORM, S  | R.   |  |  | me)  |  |  |  |   |  |  |  |
| ۲   | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |  |  |  |  |  |  |   |  |  |  |
|   | JEAN ECKSTORM/WIFE  618 LOVE POINT ROAD, STEVENSVILLE, MARYLAND 21666  20a. Method of Disposition (Name of cemetery, crematory or other place)  Date  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Town, State  |  |   |  |  |  |  |  |  |  |   |  |  |  |
| -   |  |  | 3 □Removal from   |  | Place of Dispo<br>cemetery, crei   | sition (Name of<br>matory or other place   | ) MAT  | Date RCH 28  | 20c. Location  | n - City or To   | own, State  |  |  |  |
|   | 4 Donation 5   | 5 ☐ Other (5   | Specify)  |  |  | LLE CEMET  | ERY 20   | 008  |  |  | , MARYLA  |  |  |  |
|   | 21. Signature of Fund  | eral Service   | Licensee  | 20   |  | Name and Address   |  |  |  |  |   |  |  |  |
|   | 23a. Pan Entri the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear refine. List only one of the chiline.  Approximate Interval Between Onset and Death  |  |   |  |  |  |  |  |  |  |   |  |  |  |
|   | Immediate Cause (Final disease or condition a. PEPTIC ULCER DISEASE 5 MONTHS   |  |   |  |  |  |  |  |  |  |   |  |  |  |
|   | disease or condition resulting in death)  PEPTIC ULCER DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |   |  |  |  |  |  |  |  |   |  |  |  |
|   |  |  |   |  |  | EASE   |  |  |  |  |   |  |  |  |
|   | resulting in death)  Sequentially list cond  | ditions.   | Due to (  | or as a consec   | quence of):  | EASE   |  |  |  |  |   |  |  |  |
| iner  | resulting in death)  Sequentially list conc if any, leading to imm cause. Enter Underly  | nediate<br>vina  | Due to (  |  | quence of):  | EASE   |  |  |  |  |   |  |  |  |
| xaminer   | resulting in death)  Sequentially list cond  | nediate<br>ying<br><sub>ijury</sub>  | b   | (or as a consec  | quence of):  | EASE   |  |  |  |  |   |  |  |  |
| al Examiner   | Sequentially list concif any, leading to imm cause. Enter Underly Cause (Unsease or in that initiated events   | nediate<br>ying<br><sub>ijury</sub>  | b   | or as a consec   | quence of):  | EASE   |  |  |  |  |   |  |  |  |
| cal   | Sequentially list concif any, leading to imm cause. Enter Underly Cause (Unsease or in that initiated events   | nediate<br>ying<br><sub>ijury</sub>  | b   | (or as a consec  | quence of):  | EASE   |  |  |  |  |   |  |  |  |
| cal   | resulting in death)  Sequentially list condificant, leading to immoduse. Enter Underly Cause (Disease on inthat initiated events resulting in death) La  IF FEMALE: 23b. Was decedent p  | nediate<br>ying<br>yury<br>ast   | Due to ( b  | (or as a consection as a conse | quence of): quence of): quence of):  |  |  |  |  | Date of delive   | 5 MONTH   |  |  |  |
| cian/Medical  | resulting in death)  Sequentially list concif any, leading to immouse. Enter Underly Cause (Disease of in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent print the past 12 mr 1 □ Yes 2 □  | nediate ying jury sst  pregnant nonths?  | Due to ( b  | (or as a consection as a cons  | quence of): quence of): quence of): ancy al death 3 E  | Ectopic pregnancy  |  |  |  | Date of delive   | 5 MONTH   |  |  |  |
| Physician/Medical                                   | Sequentially list condificant, leading to immicause. Enter Underly Cause (Ursease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown   | nediate ying jury ast  pregnant nonths? No   | Due to ( b  | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Edeath 5 Edeath  | Ectopic pregnancy  | n in Part I  | 23e. Did t   |  | Month  | 5 MONTH   |  |  |  |
| by Physician/Medical                                | Sequentially list condificant, leading to immicause. Enter Underly Cause (Ursease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown   | nediate ying jury ast  pregnant nonths? No   | Due to ( b  | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Edeath 5 Edeath  | Ectopic pregnancy  | n in Part I.   | 23e. Did t   | obacco use co  | Month  | ery Year Day Year   |  |  |  |
| by Physician/Medical                                | Sequentially list condificant, leading to immicause. Enter Underly Cause (Ursease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown   | nediate ying jury ast  pregnant nonths? No   | Due to ( b  | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Edeath 5 Edeath  | Ectopic pregnancy  | n in Part I.   | 10   | obacco use co  | Month<br>entribute to th<br>3 ☐ Prob   | ery Day Year he cause of death  |  |  |  |
| mpleted by Physician/Medical                        | Sequentially list condificant, leading to immicause. Enter Underly Cause (Ursease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown   | nediate ying jury ast  pregnant nonths? No   | Due to ( b  | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Edeath 5 Edeath  | Ectopic pregnancy  | n in Part I.   | 1 🗆 \\ 24a. Was autor perfo  | obacco use co<br>Yes 2 X No<br>an 24th<br>oby  | ontribute to the second of the | eny Day Year  the cause of death bably 4 Unknown psy findings avail- mpletion of cause  |  |  |  |
| Completed by Physician/Medical                      | Sequentially list condificant, leading to immicause. Enter Underly Cause (Ursease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent pin the past 12 m 1 Yes 2 9 Unknown   | pregnant<br>nonths?<br>No  | Due to (b   | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Edeath 5 Edeath  | Ectopic pregnancy Other (specify)  |  | 24a. Was<br>autop<br>perfo<br>1 Yes  | obacco use co<br>res 2 👿 No<br>an<br>ssy<br>rmed?<br>2 💆 No  | ontribute to the second of the | eny Day Year ne cause of death bably 4 Unkn   |  |  |  |
| o Be Completed by Physician/Medical                 | resulting in death)  Sequentially list conditions, leading to immoduse. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent point the past 12 moduling the past   | pregnant conditions and to medical   | Due to (b   | (or as a consection as a consection as a consection pf pregneral trime of cown   | quence of): quence of): quence of): ancy al death 3E death 5E  | Ectopic pregnancy Other (specify)  | 26. Place of Dea   | 24a. Was autoperfor 1 Yes ath (Check only continuous)  | obacco use co<br>fes 2 No<br>an 24t<br>ssy<br>rmed?<br>2 No  | ontribute to the amount of the second of the | eny Day Year  ne cause of death cably 4 Unkn opsy findings avail mpletion of cause 2 \( \) No   |  |  |  |
| To Be Completed by Physician/Medical                | Sequentially list concif any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent proceeding in the past 12 mround 12 | pregnant nonths? No cant conditions and to medical to  | Due to (b. Due to (c. Due to (d. | (or as a consection of as a consection of as a consection of   | quence of): quence of): quence of): ancy al death 3E death 5E  | □Ectopic pregnancy □ Other (specify)  nderlying cause given  | 26. Place of Dea<br>r: 4 ☐ Nursing H<br>at   | 24a. Was autoperfor 1 Yes ath (Check only continuous)  | obacco use co<br>/es 2 No<br>an 24t<br>ssy<br>rmed?<br>2 No<br>ne)   | ontribute to the second of the | eny Day Year  ne cause of death bably 4 Unkn psy findings avail mpletion of cause   |  |  |  |
| To Be Completed by Physician/Medical                | Sequentially list condificant, leading to immease. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent properties and the past 12 mround past 1 | pregnant nonths? No cant condition  5 Pendin investi   | Due to (b. Due to (c. Due to (d. | (or as a consection as a cons  | quence of): quence of): quence of): ancy al death 3E death 5E sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity alternative of the sulting in the unity of the sulting in the sulti | Dectopic pregnancy Other (specify)  Inderlying cause given  Interpolate 3 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate 4 DOA Other  Interpolate | 26. Place of Dea<br>r: 4 ☐ Nursing H<br>at   | 24a. Was autop performed to the control of the cont | obacco use co<br>/es 2 No<br>an 24t<br>ssy<br>rmed?<br>2 No<br>ne)   | ontribute to the second of the | eny Day Year  ne cause of death cably 4 Unknows psy findings avail- mpletion of cause 2 \( \) No  |  |  |  |
| cation: To Be Completed by Physician/Medical        | Sequentially list conditions, leading to immease. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent in the past 12 m 1   | pregnant nonths? No cant conditi   | Due to (b   | (or as a consection as a cons  | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Ed | DEctopic pregnancy Other (specify)  Inderlying cause given  Index 3 DOA Other  28c. Injury Work  | 26. Place of Dear r: 4 □ Nursing H at ?  | 24a. Was autop perfor 1 Yes ath (Check only colome 5 Resident 28d. Describe I  | obacco use cover 2 No  an 24th syr syr syr syr syr syr syr sy syr sy sy sy sy sy sy sy sy sy sy sy sy sy   | ontribute to the sum of the sum o | eny Day Year  ne cause of death  cably 4 Unknow  opsy findings availa  mpletion of cause 2 \( \) No   |  |  |  |
| Certification: To Be Completed by Physician/Medical | Sequentially list condificant, leading to immease. Enter Underly Cause (Unsease or inthat initiated events resulting in death) Laure (Underly Cause (Unsease or inthat initiated events resulting in death) Laure (Underly Cause (Unsease or in the past 12 mg/s) Unknown  Part II. Other signification (Underly Cause)  25. Was case referre examiner?  1   | pregnant nonths? No cant condition of Pendin investing to Could determine the property of the pregnant condition of the pr | Due to (b   | (or as a consection of as a consection of as a consection of the consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of a consection of a consection of as a consection of a consection   | quence of):  quence of):  quence of):  ancy al death 3 Edeath 5 Ed | DEctopic pregnancy Other (specify)  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given   | 26. Place of Dear r: 4 □ Nursing H at ? des 2 □ No   | 24a. Was autor period 1   Yes ath (Check only of the check only of | obacco use covers 2 No 24th say No 24th sa | ontribute to the second of the | eny Day Year  ne cause of death bably 4 Unknow psy findings availampletion of cause 2 No  WHOSPICE  |  |  |  |
| Certification: To Be Completed by Physician/Medical | Sequentially list condit any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent properties of the past 12 mm of | pregnant nonths? No cant condition  5 Pendin investi 6 Could determ  | Due to (b. Due to (c. Due to (d. | (or as a consection as a conse | auence of):  quence of):  ancy al death 3E death 5E sulting in the unity  28b. Time of Injury  owne, farm, str   | DEctopic pregnancy Other (specify)  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given  Inderlying cause given  Other  Inderlying cause given  Other  Inderlying cause given   | 26. Place of Dea r: 4 □ Nursing H at r: es 2 □ No  | 24a. Was autop performent of the control of the con | obacco use codes 2 No an 24th say rmed? 2 No ne) dence 6 No owninjury occ Street and Nur vn, State) cause(s) and   | ontribute to the solution of t | eny Day Year  ne cause of death cably 4 Unknown opsy findings avails mpletion of cause 2 No  NO SPICE  al Route Number, stated.             |  |  |  |
| cation: To Be Completed by Physician/Medical        | Sequentially list condificant, leading to immease. Enter Underly Cause (Disease or intrat initiated events resulting in death) La  IF FEMALE: 23b. Was decedent properties and the past 12 mround past 12 | pregnant nonths? No cant condition  5 Pendin investi 6 Could determ  | Due to (b. Due to (c. Due to (d. | (or as a consection as a cons  | auence of):  quence of):  ancy al death 3E death 5E sulting in the unity  28b. Time of Injury  owne, farm, str   | DEctopic pregnancy Other (specify)  Inderlying cause given  Inderlying cause g | 26. Place of Dear  T 4 Nursing H at  es 2 No  e, date and place pinion, death occur number | 24a. Was autop performent of the control of the con | obacco use codes 2 No an 24t say rmed? 2 No ne) dence 6 No now injury occ  | Month  ontribute to the state of the state   | eny Day Year  the cause of death cably 4 Unknown of cause 2 No  WHOSPICE  at Route Number, tated.  to the cause(s)                          |  |  |  |
| Certification: To Be Completed by Physician/Medical | resulting in death)  Sequentially list condit any, leading to immercause. Enter Underly Cause (Disease or in that initiated events resulting in death) La  IF FEMALE: 23b. Was decedent print the past 12 mrint past | pregnant nonths? No cant conditions of the condi | Due to (b. Due to (c. Due to (d. | (or as a consection as a cons  | auence of):  quence of):  ancy al death 3E death 5E sulting in the unity  28b. Time of Injury  owne, farm, str   | DEctopic pregnancy Other (specify)  Inderlying cause given  Inderlying cause g | 26. Place of Dea r: 4 ☐ Nursing H at r: es 2 ☐ No e, date and place                        | 24a. Was autop performent of the control of the con | obacco use codes 2 No an 24t say rmed? 2 No ne) dence 6 No now injury occ  | ontribute to the second of the | eny Day Year  the cause of death bably 4 Unkn spsy findings avail mpletion of cause 2 No  WHOSPICE  at Route Number, tated. to the cause(s) |  |  |  |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, leading to immeasure. Enter Underly Cause (Disease or intrat initiated events resulting in death) Laure (Disease or intrat initiated events resulting in death) Laure (Disease or intrating in the past 12 m 1 may 12 m 1 may 12 m 1 may 12 m 1 may 12 m 1 may 12 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1  | pregnant nonths? No cant condition of the condition of th | Due to (b. Due to (c. Due to (d. | (or as a consection as a conse | quence of): quence of): quence of): quence of): ancy al death 3 [ death 5 [ death 5 [ ] ER/Outpatier   | DEctopic pregnancy Other (specify)  Inderlying cause gives  Inderlying cause g | 26. Place of Dear  T 4 Nursing H at  es 2 No  e, date and place pinion, death occur number | 24a. Was autop performent of the control of the con | obacco use codes 2 No an 24t say rmed? 2 No ne) dence 6 No now injury occ  | Month  ontribute to the state of the state   | eny Day Year ne cause of death cably 4 Unkn psy findings avail mpletion of cause 2 No  No  No  No  No  No  No  No  No  No                   |  |  |  |

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Educational Psychologist

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

LuLu May Tait

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be (

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Augustus Omwake

Gollege (1-4or 5+)

**Funeral** 

Director

Physician /Medical Examiner

After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| 15                             | •  |  |   |  |   | _ |
|--------------------------------|--|--|---|--|---|---|
|                                | 19a. Informant's Name/Relationship (Type. Prin   | nt) 19b. Mailing Ad  | dress (Street and Number or Rural                 | Route Number, City or                            | Town, State, Zip Code)  |   |
|                                | Andrew Eckerson hu   | usband 3517 O  | uebec St NW Wash                                  | ington DC  | 20016   |   |
|                                |  | 3317 9   | debec be no wasi.                                 | iniguil ic.                                      | 20010   |   |
|                                | 20a. Method of Disposition   | 20b. Place of Disposition  | (Name of Da                                       | ate 20c. Loc                                     | cation - City or Town, State  |   |
|                                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova  | al from State cemetery, cremator   | y or other place)                                 |  |   |   |
|                                | 4- Donation 5 ☐ Other (Specify)  |  |   |  |   |   |
| ,                              | 21. Signature of Funeral Service Licensee  | <del>- George wasn</del>   | ington Univ Marc                                  | <del>:h 20,2008</del>                            | - Washington DC   | _ |
|                                | 21. Signature by different dervice cicensee  | 7  | ington Univ Marc<br>ne and Address of Facility Co | olumbia Mor                                      | tuary Sĕrvices  |   |
| 4                              | Dulla inst   | 21/1/2 901   | 3 Annapolis Rd.                                   | Lanham MD  | 20706   |   |
|                                | 220 Parts Enter the disease or complication  |  |   |  |   | _ |
|                                | 23a. Party. Enter the disease, or complications shock, or heart failure. List only one caus  | se on each line.   | rnoue or dying, such as cardiac or                | r respiratory arrest,                            | Approximate<br>Interval Between   |   |
|                                | Immediate Cause (Final   |  |   |  | Onset and Death   |   |
|                                | disease or condition resulting in death)   | Bilateral Pneumoni   | a   |  | 10 +  |   |
|                                |  | Due to (or as a consequence of):   |   |  |   | _ |
| •                              |  |  |   |  |   |   |
| Η,                             | Sequentially list conditions. b  | Urosepsis  |   |  | 10  |   |
| و 🏴                            | if any, leading to immediate   | Due to (or as a consequence of):   |   |  | 10  |   |
| 1-5                            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |   |  |   |   |
| 7                              | that initiated events c  | Encephalopathy   |   |  | 10  |   |
| Evaminer                       | resulting in death) cast   | Due to (or as a consequence of):   |   |  |   |   |
|                                |  | Dielekara Managari (   |   |  |   |   |
|                                | d  | Diabetes Mellitis 1  | 'ype II m   |  | 10  | _ |
| ď                              | S  |  |   |  |   | _ |
| 2                              | IF FEMALE: 23c If v  | es, outcome pf pregnancy   |   |  |   |   |
| 2                              | 23b. Was decedent pregnant   |  | pic pregnancy                                     | 2  | 3d. Date of delivery  |   |
| 3                              | in the past 12 months? 1 ☐ Yes 2 ☒ No  | Pregnant at time of death 5 Othe   | er (specify)                                      |  | Month Day Year  |   |
| 0                              | 9 UnknownX 9□  | Unknown  |   |  |   |   |
| Completed by Physician/Medical | Don't I Other simulations and distance and d |  |   |  |   | - |
| ≥                              | Part II. Other significant conditions contributing   | ig to death but not resulting in the underly   | ing cause given in Part I.                        | 23e. Did tobacco us                              | se contribute to the cause of death?  |   |
| =                              | Upper Gastro intes   | tinal bleeding   |   | 1 ☐ Yes 2 ☐                                      | No 3 Probably 4 Unknown   |   |
| 4                              |  |  |   |  |   | _ |
| 2                              | <u> </u>   |  |   | 24a. Was an autopsy                              | 24b. Were autopsy findings available prior to completion of cause of death? | į |
| 1 2                            |  |  |   | performed?                                       | death?  |   |
| 0                              | <u> </u>   |  |   | 1□ Yes 2□ No                                     | 1 ☐ Yes 2 ☐ No  |   |
| å                              | 25. Was case referred to medical examiner?   |  | 26. Place of Death                                | (Check only one)                                 |   | _ |
| 100                            |  | l:<br>1 ☑Inpatient 2 ☐ ER/Outpatient 3[  | Other   | ne 5□Residence 6                                 | Пон (О¥-)   |   |
| 1                              | 27. Manner of Death 28a  | . Date of Injury 28b. Time of  | T T T T T T T T T T T T T T T T T T T             |  |   | _ |
| 5                              | 1 Natural 5 Pending  | (Month, Day Year) Injury   | 28c. Injury at 2. Work?                           | 8d. Describe how injury                          | occurred  |   |
| 1                              | 2 Accident investigation   | M  |   |  |   |   |
| 3.                             | 3 Suicide 6 Could not be 380   | Place of injury. At home form street f   | noton, office                                     | 01.1   |   | _ |
| 1                              | 4 ☐ Homicide determined 206.   | <ul> <li>Place of injury - At home, farm, street, fa<br/>building, etc. (Specify)</li> </ul> | actory, office                                    | or. Location (Street and<br>City or Town, State) | d Number or Rural Route Number,   |   |
| Certification.                 |  |  |   | , ,  |   |   |
|                                | 29a. Certifier Certifying Physician:   | To the best of my knowledge, death ass   | send at the time data and along                   |  |   | _ |
| 2                              | (Check only 2 Medical Examiner: Or   | To the best of my knowledge, death occur, the basis of examination and/or investig           | ration in my opinion death occurre                | ind due to the cause(s)                          | and manner as stated.   |   |
| Medical                        | one) an  | id manner stated.  | ganon, in my opinion, death occurre               | od at the time, date and                         | place, and due to the cause(s)  |   |
| 2                              | 29b. Signature and title of certifier  | 0  | 29c. License number                               | 29d Date   | e signed (Month, Day, Year)   | _ |
|                                |  | 2010/12 17   |   | 250. Daic  | , signed (worth, bay, rear)   |   |
|                                |  |  |   | i  | A .   |   |
|                                | 1 Man 6- (XVel   | emple )  | D042040   | 1/(1   | h 22md 2000   |   |
|                                | Man 6- Clel  | enjoee )   | D042049   | Marc   | h 22n 2008  |   |
|                                | 30 Name and address of person who complete   | ad cause of death (Item 23a) (Type, Print)   | D042049   | Marc   | h 22n 2008  |   |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 6 2008

32. Registrar's Sign

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:15A M NORMAN VICTOR FILBERT 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) ali Spur COMMICO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Months 1**X** M 2□ F MARYLAND 215-22-6269 79 APRIL 25, 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No MARYLAND SOMERSET PRINCESS ANNE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30550 LIBBY LANE 21853 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 **X**Yes 2 □ No If Yes, Give Year or Dates:**1946–1956** 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗶 No Specify Specify: WHITE 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BRICK AND STONE MASON SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MYRTLE RICHARDSON ROY FILBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ADAM FILBERT/SON 30550 LIBBY LANE, PRINCESS ANNE, MARYLAND 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH 27 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) LORRAINE PARK CEMETERY 2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause do each line. Careenome with Lung Meter tas Immediate Cause (Final Gastrice disease or condition resulting in death) Due to (or as a consequence of): Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1☐ Yes 2K No

**Physician** /Medical **Examiner** 

certificate be executed

Box 68760,

P.O.

Records,

or Vital

Division

CESSE

Department of Health a Important: If item 27 is any injury or other tra

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

၉

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 2121

Examine Physician/Medical

attending physician and for use as the burial-trar signed by the a þ Completed Be ၉

certificate

After this

or Attending

To the Hospital

death.

24 hours after death e Funeral Director:

within 2

completely filled in by the funeral

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

Hospital: 1 Inpatient 28a. Date of Injury

(Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 BOther (Specify) HOS PLCE 28d. Describe how injury occurred

27. Manner of Death 1 Matural 2 ☐ Accident 3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D29505

03-23-2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR. SALISBURY, M.D. 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 6 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:40 AM **Physician** 36 3008 Vincent Stetson Free March /Medical 4c. County of Death City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner lanokin rrianor Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Davs Months 1 X M 2□ F 579-03-2999 Director 94 09-04-1913 Kentucky Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 ie marked other then "natural", or itema 23a or 28a-1 ehov other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26522 Harbor Road 21853 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 le marked other then "nu Elementary/Secondary (0-12) College (1-4or 5+) 12 none Law Enforcement Police Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Free Louise Stetson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Ie m any injury or other traum 2002. 26522 Harbor Road, Princess Anne, MD 21853 Peggy Beall/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury U.M. Cemetery 03/31/2008 Mount Vernon, Maryland 4 □Donation 5 □ Other (Specify) Signature of Fundal S 22. Name and Address of Facility
Hinman Funeral Home Princess Anne, MD 21853 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00295 11673 Somerset Ave., Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASEN) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No i or Attending Physician: after death. Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerel L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3/26/08 NIL 147094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 2/804 SACISBUMY 5. DIV. SNEW 12 EB VEL NATEGAN 1415 31. Date filed (Month, Day, Year) MAR 2 strar's Signature State Registrar

DHMH 17 Rev 1/2001

3:40Am

ORIGINAL

|   | _               | For<br>State<br>Registrar  |   | ryland / Depa<br><i>Cei</i>   | rtificate of L  |  |   | leg. No.   | 3. Time of Death   |
|---|-----------------|--|---|---|---|--|---|--|--|
| Physicia<br>/Medic  | <               | Decedent's Name (First, Middle, La JOSE)   | PH HANFORD  | GERBER  |   |  | Month<br>MAR                                | Day Year   |  |
| Examin  |                 | 4a. Facility Name (If not institution, gir<br>NATIONAL NAVAL M   | · ·   | ER  | 4b. City, Town, or BETH                                       | Location of Death                                      |   | 4c. County of De                                     |  |
| Funeral<br>Director   |                 | Social Security Number 6.  |   | (In yrs. last birthday)<br>99 Yrs.                                  | If Under 1 Year<br>Months Days                                | If Under 24 Hrs. Hours Min.                            | 8. Date of Birth<br>(Month, Day<br>Dec 5,   | 1908 Nev   | irthplace (State or Foreign<br>Country)<br>V York                        |
| aryland<br>show<br>d at   | _               | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or Lo   | cation  |  |   |  | 10d. Inside City Limits  |
| vith the Ma<br>or 28a-f s<br>be notified  | Direc           | MD Montgome  10e. Street and Number  |   | Potomac   | 10f. Zip Code 20854   |  |   | 10g. Citizen of What (                               |  |
| be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | / Funeral       | 11215 Seven Locks  11. Marital Status  1 Never Married 2 Married   | 12. Was Decedent E<br>Armed Forces?<br>1 12 Yes 2 N<br>If Yes, Give<br>Year or Dates: | 0   | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒No          | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>Rican, etc.)           |  |  |
| in 72 hours<br>n "natural",<br>Aedical Exa  | Completed by    | 3 Widowed 4 Divorced  15. Decedent's E (Specify only highest g   | ducation<br>ade completed)  | 16a. Dece<br>(Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of work<br>d)                     | king  | 16b. Kind of Busines                                 |  |
| filed within<br>Hygiene.<br>other than '  |                 | Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las   | College (1-4or 5-<br>5+   | Physi   | cian  | 18. Mother's Nam                                       | e (First, Middle,                           | Public Hea   | alth   |
| should be and Mental in marked or umatic eve  | To Be           | Julius Gerber  |   | 405 86-11   | - Address (Chrock   | Lena Sch   |   | er, City or Town, State                              | Zin Code)  |
| and 2<br>ealth a<br>n 27 is<br>ier trai   |                 | 19a. Informant's Name/Relationship  Robert H. Gerber/  |   | 6509  | Lone Oak  | Drive Be   |   |  |  |
| Pages 1<br>nent of Hi<br>ant: If iter<br>ury or oth   |                 | 20a. Method of Disposition  1 Burial 2 XCremation 3  4 Donation 5 Other (Special Contents)   |   | 20b. Place of Dispo<br>cemetery, cre<br>Chesapea                    | matory or other place ke Cremat                               | cory 03/   | 26/08                                       | Beltsvill  |  |
| permit. Pag<br>Department<br>Important: I<br>any Injury o   |                 | 21. Signature of Funeral Service Lice  21. Signature of Funeral Service Lice  22. Part 1. Enter the disease, or co   | Leuth   | MO1251 B  | everly L.   | Heckrot  | te, P.A.                                    |  | Box 784<br>11e, MD 210   |
| ficate be executed    Medical   | edical Examiner | shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. CON  Due to (or as a  b. PNI  Due to (or as a                                      | A consequence of):  EUMONIA  a consequence of):  a consequence of): | EART FAIL   | URE  |   |  | Onset and Death  |
| ath certi<br>attending<br>for use a   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown               | 2 Fetal death 3   | ⊒Ectopic pregnanc<br>⊒ Other <i>(specify)</i> _               | у  |   | 23d. Date of Month                                   | delivery<br>Day Year   |
| quires that the signed by the signed by the details   | þ               | Part II. Other significant conditions  | contributing to death be  | ut not resulting in the u   | underlying cause giv  | ven in Part I.   | 23e. Did t                                  | 77   | e to the cause of death?<br>Probably 4 □Unkno                            |
|   | Completed       |  |   |   |   |  | 1□ Yes                                      | psy prìor<br>ormed? death<br>2∭No 1⊟Y                | autopsy findings availa<br>to completion of cause<br>1?<br>'es 2 \sum No |
| o io  | To Be           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  | Hospital: 1   Inpatie   |   | III JU DOA  |  | lome 5 ☐ Resi                               | dence 6 Other (S                                     | Specify)   |
| or Attending ifter death. Director: After in by the fune  | Certification:  | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine  | be 28e Place of init  | y Year) Injury<br>ury - At home, farm, s                            | M 1□  | Yes 2 □ No   |   | how injury occurred  Street and Number or wn, State) | Rural Route Number,  |
| Hospital 24 hours a Funeral I   | Medical Ce      | 29a. Certifier 1 💢 Certifying (Check only one)   | Physician: To the best<br>aminer: On the basis o<br>and manner sta                    | f examination and/or i  | ith occurred at the t<br>nvestigation, in my                  | ime, date and place opinion, death occ                 | I<br>e, and due to the<br>urred at the time | cause(s) and manne<br>, date and place, and          | r as stated.<br>due to the cause(s)                                      |
| To the within 2   | Med             | 29b. Signature and title of certifier  |   | 50  | 29c. Licen  |  |   | 29d. Date signed (M                                  |  |
| ) am  |                 | 30. Name and address of person wh  |   | eath (Item 23a) (Type<br>MC USN                                     | , Print) NAT  |  |   | CAL CENTER   |  |
|   | ate<br>rar      | 31. Date filed (Month, Day, Year)  MAR 2 8   | 32. Registr   | ar's Signature  |   | HESDA MD   | <u> </u>                                    | סטט  |  |

|           |   |  | For<br>State<br>Registrar   | State o  | f Marylar                       |                  | artment of<br>rtificate of            |                      |              |                  | giene,<br>Reg. No.          | 2008                     | entry (de la company)                         | 762               |
|-----------|---|--|---|--|---------------------------------|------------------|---------------------------------------|----------------------|--------------|------------------|-----------------------------|--------------------------|---|-------------------|
|           |   |  | Decedent's Name (First, Middle)   | , Last)  |                                 |                  | imouto or                             |                      |              | 2. Date of Dea   |                             |                          | 3. Time                                       | of Death          |
| и         | Physici   |  | Many Anna Chan  | م م م م ا  |                                 |                  |                                       |                      |              | Month            | Day                         | Year<br>2008             | 3:16  | 4 M               |
|           | /Medio  |  | Mary Anne Gran  4a. Facility Name (If not institution   |  | mber)                           |                  | 4b. City, Town,                       | or Location of       |              | much             | 1                           | County of Deat           |   |                   |
|           | Examir  | ier  |   |  |                                 |                  |                                       |                      |              |                  |                             | Washin                   |   |                   |
|           | Funeral   |  | Washington Cou  5. Social Security Number   | 6. Sex   | 7. Age (In yrs.                 | last birthday)   | If Under 1 Yea                        |                      |              | 8. Date of Birt  | h                           | 9. Birt                  | hplace (State                                 | or Foreign        |
| ь         | Director  |  | 181-14-2323   | 1 □ M 2 💢 F  | 91                              | Yrs.             | Months Days                           | Hours                | Min.         | (Month, Day      | , Year)<br>1917             | Co                       | <sub>uintry)</sub><br>nsy1va                  |                   |
|           |   |  | Usual Residence of Decedent   |  | 91                              |                  |                                       |                      |              | reb. /           | 171                         | 1 1 611                  | поутуа  | пта               |
|           | ylanc<br>iow  |  | 10a. State 10b. County  |  | 10c. Ci                         | ty, Town or Lo   | cation                                |                      |              |                  |                             |                          | 10d. Inside                                   | City Limits       |
|           | Mar<br>fied   | ţō   | Maryland Washi  | noton  |                                 | Fair             | nlav –                                |                      |              |                  |                             |                          | 1 □Ye   | s 2 No            |
|           | r 28a   | Director   | 10e. Street and Number  | ngton  |                                 | 1411             | 10f. Zip Code                         |                      |              |                  | 10g. Citiz                  | en of What Co            | untry?  |                   |
|           | 3a o  | <u>=</u>   | 8927 Jordan Roa   | d  |                                 |                  | 21733                                 | 3                    |              |                  | 1                           | JSA                      |   |                   |
|           | ns 2<br>mus   | Funeral  | 11. Marital Status  | 12. Was Dec  | edent Ever in U                 | J.S. 13. \       | Was Decedent of<br>f Yes, specify Cu  |                      | igin? (Spe   | cify Yes or No   |                             | 4. Race - Ame            |   |                   |
| <b>10</b> | r iter  | Ξ  | 1 ☐ Never Married 2 🗓 Marri   | Armed Fo   | 2 No                            |                  |                                       |                      |              | Rican, etc.)     |                             | Black, White             | e, etc.                                       |                   |
| 33        | al", o  | by   | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Gi<br>Year or D  | ve                              |                  | I∐Yes 2M∏ No                          | Specify:             |              |                  | Specify: White              |                          |   |                   |
| 215-0036  | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notitied at  | Completed  | 15. Decedent  | 's Education   |                                 | 16a. Deced       | lent's Usual Occi                     | upation              |              |                  | 16b. Kind of Business/Indus |                          |   |                   |
| 715       | hin 7   | ble  | (Specify only highes<br>Elementary/Secondary (0-12)   | College (  | 1-4or 5+)                       | life. l          | kind of work done OO NOT use retir    | e auring mos<br>red) | it of workir | ng               |                             |                          |   |                   |
| 212       | filed withi<br>Hygiene.<br><b>other than</b><br>ent, the M  | E O  | 12  | 4  | 1 40/01)                        | Te               | acher                                 |                      |              |                  |                             | Musi                     | С   |                   |
|           | othe<br>ent,  | Be C   | 17. Father's Name (First, Middle,   | Last)  |                                 |                  |                                       | 18. Mothe            | er's Name    | (First, Middle,  | Maiden S                    | Surname)                 |   |                   |
| a         | lid be<br>lenta<br>ked<br>lc ev   | To B   | Pasquale Cotron   | e0   |                                 |                  |                                       | An                   | gelir        | na Bifa          | no                          |                          |   |                   |
| Maryland  | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | -  | 19a. Informant's Name/Relationsh  |  |                                 | 19b. Mailir      | g Address (Stree                      |                      |              |                  |                             | Town, State, 2           | Zip Code)                                     |                   |
| Š         | nd 2<br>alith a<br>27 Is<br>r trai  |  | Harry F. Grandi   | nett-Hush  | and                             | 8927             | Jordan                                | Road.                | Fair         | nlav.            | Marv <sup>1</sup>           | land 21                  | 733   |                   |
| ē,        | of Health of Health item 27 I   |  | 20a. Method of Disposition  |  | 20b.                            | Place of Dispo   | sition (Name of<br>natory or other pl | (000)                |              | ate              |                             | ation - City or          |   |                   |
| no        | Pages<br>nent of h<br>int: if ite   |  | 1 ☐ Burial 2 🖾 Cremation<br>4 ☐ Donation 5 ☐ Other (Si  |  | State                           |                  | own Crem                              | 1                    | 2/21         | /08              | Unco                        | rstown,                  | Marsi   | land              |
| Baltimore | artime<br>ortan   |  | 21. Signature of Funeral Service  |  | П                               |                  | . Name and Add                        |                      |              |                  |                             | neral H                  |   | Lanu              |
| Ba        | permit. Pages<br>Department of<br>Important: If if<br>any Injury or once.   |  | 16001   | 0 0 -  |                                 |                  | 15 E. Wi                              |                      | •            |                  |                             |                          |   | 1740              |
|           | _   | -  | 23a. Part1. Enter the disease, or   | complications that   | caused the dea                  |                  |                                       |                      |              |                  |                             | 19 1141 9                |   |                   |
|           |   |  | shock, or heart failure. List<br>Immediate Cause (Final   | only one cause on e  | each line.                      | B -              |                                       |                      |              |                  | •                           |                          | Approximately Approximately Interval Boundary | etween<br>d Death |
| ï         | Physician<br>/Medical   |  | disease or condition resulting in death)  | a. Chy   | Or as a consec                  | Obstu            | uru                                   | pull                 | Mo           | my de            | sea                         | u                        | 54.   | lows              |
|           | Examiner  |  | ,   |  |                                 |                  |                                       |                      |              |                  |                             |                          |   |                   |
|           |   | <u>.</u>   | Sequentially list conditions,   | Sequentially list conditions, farry, leading to immediate  b.   Cidney desicor  Due to (or as a consequence of): |                                 |                  |                                       |                      |              |                  |                             |                          |   | e.                |
|           | ed sit  | Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to   | (Or as a corrise                | guerice or).     |                                       |                      |              |                  |                             |                          |   |                   |
|           | and -tran   | хап  | that initiated events<br>resulting in death) Last   | c  | (or as a consec                 | anence of/:      |                                       |                      |              |                  |                             |                          |   |                   |
| 60,       | oe ey   | 三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田  |   | a Due to   | (01 43 4 0011360                | querice ory.     |                                       |                      |              |                  |                             |                          |   |                   |
| 68760,    | cate be executed<br>physician and<br>the burial-transit   | dical  |   | d  |                                 |                  |                                       |                      |              |                  |                             |                          |   |                   |
| _         | as as   | Me   | IF FEMALE:  | 00- 14   |                                 |                  |                                       |                      |              |                  |                             |                          |   | -                 |
| Вох       | death certifi<br>e attending<br>d for use as  | ian/   | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐Live  | tcome pf pregn<br>birth 2 ☐ Fet | aldeath 3□       | Ectopic pregnan                       | ісу                  |              |                  | 2:                          | 3d. Date of del<br>Month | ivery<br>Day                                  | Year              |
|           |   | sic  | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4∐Pregi<br>9⊡Unkn  | nant at time of                 | death 5L         | Other (specify)                       |                      |              |                  |                             |                          | ,   | ,                 |
| P.0       | The law requires that the death cer<br>ate has been signed by the attendin<br>page 2 should be detached for use   | Physician/Me   | 772   |  |                                 | and the state of |                                       | don de Book I        |              | Did A            |                             | se contribute to         | Ab  |                   |
|           | res the   | by   | Part II. Other significant condition  | ins contributing to d  | eath but not res                | sulling in the u | idenying cause g                      | jivenin Fanti        |              |                  |                             |                          |   |                   |
| Records,  | w requir<br>been si<br>should   | Completed  |   |  |                                 |                  |                                       |                      |              | 101              | res 2                       | ]No 3∏Pr                 | obably 4                                      | Unknown           |
| ec        | law r<br>as be<br>2 sh  | ple  |   |  |                                 |                  |                                       |                      |              | 24a. Was         |                             | 24b. Were au             | topsy finding                                 |                   |
| 8         | : The lav<br>cate has<br>page 2:  | mo:  |   |  |                                 |                  |                                       |                      |              |                  | rmed?<br>2 No               | death?<br>1 ☐ Yes        |   |                   |
| or Vital  | Iclan: Th<br>certificate<br>ector, pag  | Be C   | 25. Was case referred to medical  | · .  |                                 |                  |                                       | 26. Place            | e of Death   | (Check only o    |                             |                          | 7   |                   |
| >         | ys<br>dir   | ToB  | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital:  | npatient 2                      | ]ER/Outpatier    | t 3 DOA                               | ther: 4 Nu           | ursing Hor   | ne 5□Resid       | lence 6                     | □Other (Spe              | cifv)   |                   |
| 0         | ding Ph<br>h.<br>After th<br>funeral  | n: T   | 27. Manner of Death   | 28a. Date  | of Injury<br>oth, Day Year)     | 28b. Time o      | 28c. Inj                              |                      |              | 28d. Describe I  |                             |                          | ,,  |                   |
| Division  | th.<br>r: After<br>e funera   | Certification:   | 1 Natural 5 Pending 2 Accident investig   |  | un, Day rear)                   | Injury           |                                       | ork?<br>□Yes 2□      | No           |                  |                             |                          |   |                   |
| /is       | Atte<br>r dea<br>ecto   | fice   | 3 Suicide 6 Could r<br>4 Homicide determ  | ned Zoe. Place   | of injury - At h                | nome, farm, str  | eet, factory, office                  | e                    | 2            | 28f. Location (S | Street and                  | Number or Ru             | ıral Route Nu                                 | ımber,            |
| Ö         | afte din h  | erti   | 4 [] Hornicide  | bulld  | ing, etc. (Speci                | ny)              |                                       |                      |              | City or Tov      | n, State)                   |                          |   |                   |
|           | spita<br>nours<br>nera  | al C   | 29a. Certifier 1 Certifyin  | g <b>Physician:</b> To the   | e best of my kn                 | owledge, deat    | occurred at the                       | time, date ar        | nd place, a  | and due to the   | cause(s)                    | and manner as            | stated.                                       |                   |
|           | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   | 29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Accident 3   Suicide 4   Homicide  28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Ru City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month |   |  |                                 |                  |                                       |                      |              |                  | to the cause                | e(s)                     |   |                   |
|           | vithin<br>o th  | Me   | 29b. Signature and title of certifier   |  |                                 |                  | 29c. Licer                            | nse number           |              |                  | 29d. Date                   | signed (Mont             | h, Day, Year)                                 |                   |
|           | ->-0  | Meryan Johan D18365 3-28   |   |  |                                 |                  |                                       |                      |              |                  | -28.                        | 08                       |   |                   |
|           |   |  | 30. Name and address of person  | who completed ac-  | od doath the                    | m 23a) /Time     |                                       |                      |              |                  |                             |                          |   |                   |
| 2         | H-6   |  | MAW 2AA.  |  |                                 |                  |                                       | Nac                  | rest.        | aun              | MY                          | 2171                     | O   |                   |
|           | Sta   | eto  | 31. Date filed (Month, Day, Year)   |  | istrar's Sign                   |                  |                                       | - 03                 | 1-3019       |                  | 1 1                         | 11                       |   |                   |
|           | - Si  | ne   | MAD 3 1   |  | 6                               | An a             | Constanting the                       |                      |              |                  |                             |                          |   |                   |

|                   |   |                     | For<br>State<br>Registrar  |  | State of 1  | viaryianu /                           |  | rtificate                  |                         |   | wemai n                                 | Reg. N            | 0000                                   | 3 11                          | 763              |
|-------------------|---|---------------------|--|--|---|---------------------------------------|--|----------------------------|-------------------------|---|---|-------------------|--|-------------------------------|------------------|
| 140               | Physici   | an                  | 1. Decedent's Nam  | ne (First, Middle, L                   | _ast)   |                                       |  |                            |                         |   | 2. Date of D<br>Month                   |                   | Day Year                               | 3. Time                       |                  |
| , iii             | /Medic  |                     |  | Lee Hig                                |   |                                       |  |                            |                         |   | March                                   | 27,               | 2008                                   | 081                           | 3 A <sup>M</sup> |
| ¥-                | Examin  | er                  | 4a. Facility Name (  | If not institution, g                  | ive street and number                                     | er)                                   |  | 4b. City, 7                | Town, or                | Location of Dea                         | th                                      |                   | tc. County of Dea                      | ath                           |                  |
|                   |   |                     | Peninsula  | a Region                               | al Medical  |                                       |  | Sali                       |                         |   |   |                   | <i>l</i> icomico                       |                               |                  |
| ь                 | Funeral   |                     | 5. Social Security N 218-16-   |  | Sex 7.<br>1 □ M 2 🔀 F                                     | Age (In yrs. last I                   | oirthday)<br>3 <sup>Yrs.</sup>           | If Under<br>Months         | Days                    | If Under 24 Hrs<br>Hours Min            | . (Month, L                             | Da <i>y</i> , Yea |  | rthplace (State<br>ountry)    |                  |
| ě.                | Director  |                     | Usual Residence o  |  |   | 8                                     | 3 <sup>rs.</sup> March 11, 1925 Maryland |                            |                         |   |   |                   |  |                               | <u> </u>         |
|                   | land<br>ow<br>tt  |                     | 10a. State   | 10b. County                            |   | 10c. City, To                         | wn or Lo                                 | cation                     |                         |   |   |                   |  | 10d. Inside (                 | City Limits      |
|                   | Mary<br>f sh  | 힏                   | MD   | Worcest                                | er  | Snow                                  | Hill                                     |                            |                         |   |   |                   |  | 1 <b>X</b> Ye                 | s 2□No           |
|                   | the rotif   | iec                 | 10e. Street and Nu   | 1                                      |   |                                       |  | 10f. Zip                   | Code                    |   |   | 10g. 0            | Citizen of What C                      | ountry?                       |                  |
|                   | 3a or   | <u></u>             | 430 West   | Market                                 | Street.   |                                       |  | 218                        | 63                      |   |   |                   | USA                                    |                               |                  |
|                   | death<br>ms 2   | Jera                | 11. Marital Status   | TRATITOC                               | 12. Was Decede  | nt Ever in U.S.                       | 13.                                      |                            |                         | ispanic Origin? (<br>In, Mexican, Pue   | Specify Yes or N                        | 10-               | 14. Race - American Indian,            |                               |                  |
| 9                 | after<br>or ite<br>nine   | by Funeral Director | 1 Never Mar  | ried 2 Married                         | Armed Force 1 ☐ Yes 2 If Yes, Give                        |                                       | - 1                                      | n res,spec<br>1 ⊟ Yes 2    |                         |   | no Hican, etc.)                         |                   | Black, White, etc.                     |                               |                  |
| 03                | ral", c   | l by                | 3 <b>X</b> Widowed   | 4 ☐ Divorced                           | Year or Date  | s:                                    |  | TLI fes 2                  | ZAJ INO                 | эреспу.                                 |   |                   | Specify: white                         |                               |                  |
| 21215-0036        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at | Completed           | (Spe   | 15. Decedent's<br>cify only highest of | Education<br>grade completed)                             | 16                                    | (Give                                    | dent's Usua<br>kind of wor | k done d                | during most of wo                       | orking                                  | 16b.              | b. Kind of Business/Industry           |                               |                  |
| 21                | ithin<br>ne.<br>nan "   | du                  | Elementary/Seco  |  | College (1-4d   |                                       | life.                                    | DO NOT us                  | e retirea               | )                                       |   | .                 | 77 <b>.</b>                            | _                             |                  |
| 7                 | lygier<br>lygier<br>lt, the   | S                   | 1  |  | 4   |                                       | Teac                                     | her                        |                         | 40 14-41-1-                             | me (First, Midd                         |                   | Education                              | U                             |                  |
| ng                | be fill   | Be                  | 17. Father's Name  |  |   |                                       |  |                            |                         |   |   |                   | ,                                      |                               |                  |
| 3                 | 12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Mec  | မ                   | Linwood  |  |   | 14                                    |  |                            | (2)                     |   | r Leah                                  |                   |  | <b>T</b>                      |                  |
| Maryland          | d 2 st<br>h and<br>7 Is n<br>traun  |                     | 19a. Informant's N   |  | (daughte  |                                       |  | u .                        | ,                       |   |   |                   | y or Town, State, MD 218               |                               |                  |
|                   | is 1 and<br>of Heatt<br>item 2  |                     | 20a. Method of Dis   |  | (dddgiico.  | 20b. Place                            | of Dispo                                 | sition (Nam                | ne of                   | 1                                       |   | Location - City o |  |                               |                  |
| Baltimore,        | Pages<br>nent of I<br>int: If ite   |                     | 1 Burial 2   | ☐Cremation 3                           | ☐Removal from Sta   | ate ce <i>me</i>                      | tery, crei                               | matory or of               | ther plac               |   | 1/5-100                                 |                   | ansburg                                |                               |                  |
| Ħ                 | iit. Partme   |                     | 4 ∐Donation  21. Signature of F  | 5 Other (Spe                           |   | St. Ja                                | -  |                            |                         | metery 4                                | 13/45                                   |                   |  |                               |                  |
| Ba                | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |                     | mus  | 4.0A                                   | Dean  |                                       | I F                                      | iollow<br>501 Sno          | ay 1<br>ow H            | ill Rd.                                 | Home, P<br>, Salisk                     | rote              | sional As<br>, MD 218                  | sociatio<br>304               | n                |
|                   |   |                     | 23a. Part1. Enter  | the disease, or co                     | mplications that caus                                     | sed the death. De                     |  |                            |                         |   |   |                   | •                                      | Approxima<br>Interval B       | ate<br>etween    |
|                   | Physician   |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  a. ATHEROSCIEROTIC CARDIOVASCULAR DISEA  resultion in death. |  |   |                                       |  |                            |                         |   |   |                   |  |                               | d Death          |
|                   | /Medical  |                     | disease or condition resulting in death)  a.   ATHEROSCIEROTIC CARDIOVASCULAR VISEASE  Due to (or as a consequence of):  |  |   |                                       |  |                            |                         |   |   |                   |  |                               |                  |
| В                 | Examiner  |                     | Convention list on   | anditions.                             | h   |                                       |  |                            |                         |   |   |                   |  |                               |                  |
|                   | ₽ .±  | ner                 | Sequentially list co<br>if any, leading to in<br>cause. Enter Undo<br>Cause (Disease of<br>that initiated event  | mmediate<br>erlying                    | Due to (or  | as a consequenc                       | e of):                                   |                            |                         |   |   |                   |  |                               |                  |
|                   | tificate be executed<br>ig physician and<br>as the burial-transit   | Examiner            | Cause (Disease or<br>that initiated event<br>resulting in death)   | rinjurý<br>s<br>Last                   | C   |                                       |  | A                          |                         |   |   |                   |  |                               |                  |
| 90,               | ian a   | ũ                   | resulting in death)  | Lust                                   | Due to (or  | as a consequenc                       | e of):                                   |                            |                         |   |   |                   |  |                               |                  |
| 68760,            | sate to<br>physical<br>the to   | edical              |  |  | d   |                                       |  |                            |                         |   |   |                   |  |                               |                  |
|                   | ding page as  |                     | IF FEMALE:   |  | 220 Have outpor   | mo of programmy                       |  |                            |                         |   |   |                   | Ond Date of delivery                   |                               |                  |
| Вох               | attend<br>for us  | ian                 | 23b. Was deceder<br>in the past 12   |  |   | n 2 Fetal dea                         |  | Ectopic pre                |                         | ,                                       |   |                   | 23d. Date of delivery  Month Day Year  |                               |                  |
|                   | the de  | Physician/N         | 1 ☐ Yes 2<br>9 ☐ Unknown   |  | 4⊟Pregnan<br>9⊟Unknowr                                    | t at time of death<br>n               | 51                                       | Other (spe                 | еспу)                   |   |   |                   |  |                               |                  |
| P.0               | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  |                     | Part II. Other signi   | Ificant conditions                     | s contributing to deatl                                   | h but not resulting                   | in the u                                 | nderlying ca               | ause give               | en in Part I.                           | 23e. Dio                                | tobacc            | o use contribute                       | to the cause of               | death?           |
| Records,          | uires<br>sign<br>id be  | d by                |  |  |   |                                       |  |                            |                         |   | 1 [                                     | Yes               | 2. No 3□ F                             | Probably 4                    | ]Unknown         |
| 00                | w red<br>beer<br>shou   | Completed           |  |  |   |                                       |  |                            |                         |   | 24a. Wa                                 | is an             | 24h. Were a                            | autopsy finding               | s available      |
| Re                | he lav<br>e has<br>ige 2 :  | ш                   |  |  |   |                                       |  |                            |                         |   | aut                                     | topsy<br>rformed  | prior to<br>death?                     | completion of                 | cause of         |
|                   |   | e C                 | 25. Was case refe  | rred to medical                        | 1   |                                       |  |                            |                         | 26 Pines of De                          | 1 Yes                                   |                   | No 1∐Ye                                | s 2 No                        |                  |
| >                 |   | m                   | examiner?  | ,                                      | Hospital: 1 ☐ Inp   | atient 2 R/0                          | Dutnatier                                | nt 3 🗆 DO                  | Othe                    | or:                                     | eath <i>(Check onl)</i>                 |                   | 6 □Other (Sp                           | onifu)                        |                  |
| Ö                 | ing Phys  | : To                | 27. Manner of Dea  | 1                                      | 28a. Date of I  | Injury 28b                            | . Time o                                 |                            | 8c. Injur<br>Worl       |   |   |                   | jury occurred                          | ecny)                         |                  |
| Division or Vital | Attending r death. ector: After by the fune   | tion                | 1 Accident   | 5 ☐ Pending investigation              |   | Day Year)                             | Injury                                   | M                          |                         | k?<br>Yes 2 □ No                        |   |                   |  |                               |                  |
| N N               | Atte  | ifice               | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Could not determine                | d   28e. Place of   | injury - At home,<br>, etc. (Specify) | farm, sti                                | eet, factory               | , office                |   | 28f. Location<br>City or T              | (Street           | and Number or F                        | Rural Route Nu                | mber,            |
| Ö                 | tal or<br>s afte<br>al Dir<br>ed in   | Certification:      | 4 1 101110140  |  | - Dullding,   | , etc. (Opechy)                       |  |                            |                         |   |   | OW/1, OI          | ale)                                   |                               |                  |
|                   | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral                                  | Medical             | 29a. Certifier<br>(Check only<br>one)  | 1 Certifying   2 Medical Ex            | Physician: To the be<br>aminer: On the basi<br>and manner | s of examination                      | lge, deat<br>and/or in                   | h occurred a vestigation,  | at the tir<br>, in my o | ne, date and place<br>pinion, death occ | ce, and due to the<br>curred at the tim | e, date           | e(s) and manner a<br>and place, and di | as stated.<br>ue to the cause | e(s)             |
|                   | o the   | Med                 | 29b. Signature and   | title of certifier                     | 1 1   | otato di                              |  | 29c.                       | . License               | e number                                |   |                   | Date signed (Mor                       |                               |                  |
|                   | PSFO  |                     |  | 20                                     | ty c/ m   | D                                     |  | 1                          | 000                     | 06217                                   | 2                                       | 5                 | 3/27 (2                                | 2008                          |                  |
|                   |   |                     | 30. Name and add   | lress of person wh                     | o completed cause of                                      | of death (Item 23a                    | ı) (Type,                                |                            |                         |   |   |                   |  |                               |                  |
| B                 | A15   |                     | SHARAD   | R SA                                   | YAL, MO;  | 1604 M                                | ARIC                                     | ET S                       | TF                      | OCO MOK                                 | ce city                                 | M                 | 2 85                                   | •                             |                  |
|                   | Sta   |                     | 31. Date filed (Moi  |  |   | istrar's Signature                    |  | 1                          |                         |   |   |                   |  |                               |                  |
|                   | Registr   | ar                  |  | MAR 2 8                                | 2008  | was St.                               | 19                                       | rede                       |                         |   |   |                   |  |                               |                  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 18, 2008 9:15 AM Raymond H. Hillsinger March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crofton Care And Rehab Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 21, 1922 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 579-18-3490 85 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be accounted. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 3615 Melfa Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes Give If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 Divorced 43-45 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Technician Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Hillsinger Sr. Agnes Fleishman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Hillsinger/WIFE 3615 Melfa Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/2008 Crownsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final odiac **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician this within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

7028

#231

29d. Date signed (Month, Day, Year)

Annapolis mp 21401

State Registrar

Medical

31. Date filed (Month, Day, Year)

Aditya

29b. Signature and title of certifier

30. Name and authess of person who completed cause of death (Item 23a) (Type, Print)

m.D



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** March 21 LV JAMES 2008 /Medical 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL 4b. City, Town, or Location of Death PRINCE GEORGES Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**X** M 2□ F JACKSON, AL Director 417-28-3165 83 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at **JACKSON** MYes 2 No AL CLARKE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 36545 239 ST. JAMES ROAD Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 □X/es 2 □ No 1943 — If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3√ Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LOGGER PULPWOOD INDUSTRY 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WESLEY JAMES VIRGINIA ROCKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET MITCHELL/DAUGHTER 6301 WOOD POINTE DR. GLENN DALE, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State .JAMES CH. 3/29/2008 JACKSON, ALABAMA CEM. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 8 to wart Kenna 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Ent. + disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. + fit only one cause on each line. Approximate Interval Between Onset and Death THROMBOCYTO PENO, A Immediate Cause (Final SEV **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner 122921D The law requires that the death certificate be executed 2000 that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 05 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unixfown Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No ို 1 Dippatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 0628 WO

State Registrar

amas

31. Date filed (Month, Day, Year) MAR 2 8 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118 GOOD LOCK ROAS, LAWHAM, MS

|  |  |                                  | For<br>State  | Stat           | e of N                        | <i>l</i> larylan         |                             | rtment of F                             |  | Mental Hy                           | giene                     | 0000                        | 1177                                | ja. |
|--|--|----------------------------------|---|----------------|-------------------------------|--------------------------|-----------------------------|---|--|-------------------------------------|---------------------------|-----------------------------|-------------------------------------|-----|
|  |  |                                  | State<br>Registrar  | 4 1)           |                               |                          | Cer                         | tificate of                             | Death                                    | T 0 D.V. (D                         | Reg. No.                  | 2003                        | 5 1/6                               | ()  |
| Phys   | siciar   | ١                                | 1. Decedent's Name (First, Middle   |                |                               |                          |                             |   |  | 2. Date of Do                       | Day                       |                             | 3. Time of Death                    | M   |
|  | edica<br>mine  | . 25                             | WARREN JONES,  4a. Facility Name (If not institution  |                | nd numbe                      | r)                       | T                           | 4b. City, Town, o                       | r Location of Deat                       | MARCH                               |                           | County of Dea               | 8:00 A                              | -   |
| EXA  | mme  | 4                                | 304 ETNA DRIVE  | , 9            |                               | .,                       |                             |   | MARLBORO                                 |                                     |                           | INCE GE                     |                                     |     |
| Fune   | ral  |                                  | 5. Social Security Number   | 6. Sex         |                               |                          | last birthday)              | If Under 1 Year<br>Months Days          | If Under 24 Hrs<br>Hours Min.            | (Month, D                           | <i>ay</i> , Yea <i>r)</i> | C                           | rthplace (State or Foreigountry)    |     |
| Direct   | tor  | -                                | 577-68-0363 Usual Residence of Decedent   | ELZMII Z       |                               |                          | 58 Yrs.                     |   |  | 11/10/                              | 1949                      | WAS                         | HINGTON, D                          | C   |
| land<br>ow   | 1  | ŀ                                | 10a. State 10b. County  |                |                               | 10c. Cit                 | y, Town or Lo               | cation                                  |  |                                     |                           |                             | 10d. Inside City Limit              | ts  |
| Many<br>a-f sh   |  | ם                                | MD PRINCE   | GEORGE         | S                             | UPP                      | ER MARI                     | LBORO                                   |  |                                     |                           |                             | 1 XYes 2 N                          | lo  |
| th the<br>or 28  |  | Director                         | 10e. Street and Number  |                |                               | _                        |                             | 10f. Zip Code                           |  |                                     | 10g. Citiz                | zen of What C               | ountry?                             |     |
| ath w  |  |                                  | 304 ETNA DRIVE  |                |                               |                          |                             | 20774                                   |  |                                     | USA                       |                             |                                     |     |
| er de<br>items   |  | Laneral                          | <ul><li>11. Marital Status</li><li>1 □ Never Married 2 ☒ Marr</li></ul>                                     | Arm            | Deceder<br>ed Forces<br>Yes 2 |                          | .S. 13. V                   | Was Decedent of H<br>f Yes, specify Cub | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or Note to Rican, etc.) | 0-                        | 14. Race - Am<br>Black, Whi |                                     |     |
| Irs aff  |  | Dy L                             | 3 ☐ Widowed 4 ☐ Divorced  | l If Ye        | es, Give<br>r or Dates        |                          | 1                           | l∐Yes <b>≱©X</b> No                     | Specify:                                 |                                     | Specify: BLACK            |                             |                                     |     |
| 2 hou rature   |  |                                  | 15. Deceden<br>(Specify only highe  | 's Education   | atad)                         |                          | 16a. Deced                  | lent's Usual Occup<br>kind of work done | pation                                   | rkina                               | 16b. Kir                  | nd of Business              | s/Industry                          |     |
| tthin 7  |  | Completed                        | Elementary/Secondary (0-12)   | Coll           | ege (1-4o                     | r 5+)                    | life. L                     | OO NOT use retire                       | d) most of wo                            | rking                               |                           |                             |                                     |     |
| led w<br>lygier<br>her th  |  |                                  | 47 Esthada Nama / First Middle  | 2 YE           | ARS_                          |                          | İ                           |   | 18. Mother's Na                          | mo /First Middle                    | PRIV                      |                             |                                     |     |
| the find the | å  |                                  | 17. Father's Name (First, Middle, WARREN JONES,   | ,              |                               |                          |                             |   |  | HOLMES                              | •                         | ourname)                    |                                     |     |
| should<br>nd Me<br>mark  |  | 2                                | 19a. Informant's Name/Relations   |                | t)                            |                          | 19b. Mailin                 | g Address (Street                       |  |                                     |                           | r Town, State,              | Zip Code)                           |     |
| alth a   |  |                                  | SHARON JONES/W  | IFE            |                               |                          | 304 E                       | INA DRIVI                               | E UPPER N                                | íARLBORO                            | , MD                      | 20774                       |                                     |     |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any inlinor or other traumatic event, the Medical Examiner must be notified at   |  |                                  | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation   | 3 DRemoval     | from Stat                     | 1 /                      | Place of Disponentery, crem | sition (Name of<br>natory or other pla  | ce)                                      | Date                                | 20c. Lo                   | cation - City o             | r Town, State                       |     |
| . Pag<br>iment<br>tant:  |  |                                  | 4 ☐ Donation 5 ☐ Other (S   | pecify)        |                               |                          |                             | TION CEM                                |  |                                     |                           | NTON, M                     |                                     |     |
| Depar<br>Mpor  | once.  |                                  | 21. Signature of Funeral Service  | Licensee       | 101                           | 1,                       | I                           | . Name and Addre                        |  |                                     |                           |                             |                                     |     |
|  |  | -                                | 23a Part1 Enter the disease of  | complications  | that caus                     | ed the deat              |                             |   |  |                                     |                           | TID 207                     | Approximate                         |     |
| Physicia   | 200  |                                  | 23a. Part1. Enter the diseale, in<br>shock, or heart failure. Lit t<br>Immediate Cause (Final               | only one cause | on each                       |                          |                             |   |  | o or roop, and the                  |                           |                             | Interval Between<br>Onset and Death | ,   |
| /Medic   | -  |                                  | disease or condition resulting in death)  | a              | ue to (or a                   | e par                    |                             | carcin                                  | own                                      |                                     |                           |                             | < 3 mout                            | 62  |
| Examin   | er   |                                  | Sequentially list conditions  | b              |                               |                          |                             |   |  |                                     |                           |                             |                                     |     |
| p it   |  | 2                                | Sequentially list conditions, if any, leading to immediate cause. Liner University Cause (Disease or injury | D              | ue to (or a                   | as a conseq              | uence of):                  |   |  |                                     |                           |                             |                                     |     |
| be executed sician and burial-transit  |  | Yall                             | that initiated events resulting in death) Last  | c              | ue to (or a                   | s a consen               | uence of):                  |   |  |                                     |                           |                             |                                     |     |
| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   |  | Due to (or as a consequence of): |   |                |                               |                          |                             |   |  |                                     |                           |                             |                                     |     |
| g physical ease the  | 3  | 20 1                             |   | 0.             |                               |                          |                             |   |  |                                     |                           |                             |                                     |     |
| death certific attending p   | of the circumstance of the | 1                                | IF FEMALE:<br>23b. Was decedent pregnant  |                |                               | ne pf pregna<br>2 □ Feta |                             | Ectopic pregnanc                        | v  |                                     | 2                         | 23d. Date of de             |                                     |     |
| e dear<br>he att   | 17   | 200                              | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4□             |                               | at time of d             |                             | Other (specify)                         |  |                                     |                           | Month                       | Day Year                            |     |
| hat the de d by the defected   | 1  |                                  | 9 ☐ Unknown  Part II. Other significant condition   |                |                               |                          | ulting in the ur            | nderlying cause giv                     | ven in Part I                            | 23a Did                             | tobacco u                 | se contribute               | to the cause of death?              |     |
| signed I   | i  | 2                                | Diabetes  | type I         | y to death                    | Dut Hot les              | ululig ili ale ul           | idenying cause giv                      | en in can i.                             |                                     |                           |                             | Probably 4 Dunknov                  | wn  |
| w requir<br>been si  | 1  |                                  | COUNTRAIN   | MITEN          | 3 0                           | lisea                    | se.                         |   |  | 24a. Was                            | s an                      | 24h Ware s                  | autopsy findings availab            | nla |
| sician: The law certificate has be received by the same of the sam | ,  | naialdilloo                      | Hungelens   | 1/110          |                               | C- <b>J</b> CO-2         |                             |   |  | auto                                | opsy<br>ormed?            | prior to<br>death?          | completion of cause or              | f   |
| ician: The certificate ector, pag  |  | ו מ                              | 25. Was case referred to medica   | 1004           |                               |                          |                             |   | 26. Place of De                          | 1  Yes<br>ath (Check only           |                           | 1 ☐ Ye                      | s 2 No                              | —   |
| _ > .ഈ ⊅   | 1.0  |                                  | examiner?<br>1 ☐ Yes 2 No   | Hospital:      | 1 🗌 Inpa                      | itient 2 🗌               | ER/Outpatien                | t 3□ DOA Oth                            | ler:<br>4 ☐ Nursing I                    | Home 5 🔀 Res                        | idence 6                  | 3 □Other (Sp                | ecify)                              |     |
| ing Pl   | i  |                                  | 27. Manner of Death  1. Natural 5 ☐ Pendin  | g              | Date of Ir<br>(Month, L       | njury<br>Day Year)       | 28b. Time of<br>Injury      | Wo                                      |  | 28d. Describe                       | how injur                 | y occurred                  |                                     |     |
| ttend<br>death.  | 1  | 2                                | 2 ☐ Accident investion 3 ☐ Suicide 6 ☐ Could  |                | Place of i                    | niun, At ho              | nme farm etr                |   | Yes 2 □ No                               | 28f Location                        | (Stroot on                | d Number or I               | Rural Route Number,                 |     |
| To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director;   |  |                                  | 4 ☐ Homicide determ   | ined 20e.      | building,                     | etc. (Specif             | y)                          | eet, factory, office                    |  | City or To                          | isireet and<br>wn, State, | )<br>)                      | turai noute Number,                 |     |
| spita<br>nours<br>neral  | 2  |                                  | 29a. Certifier 1 Certifyir  | g Physician:   | To the bes                    | st of my kno             | wledge, death               | occurred at the ti                      | me, date and plac                        | e, and due to the                   | e cause(s)                | and manner a                | as stated.                          |     |
| he Ho<br>in 24 I<br>he Fu<br>pleteli   | 1 2  | ealical                          | (Check only 2 Medical one)  |                | the basis<br>manner           |                          | ition and/or in             | vestigation, in my                      | opinion, death occ                       | urred at the time                   | e, date and               | place, and du               | ue to the cause(s)                  |     |
| To t   | 8.8  | 2                                | 29b. Signature and title of certifie  | ,              | 0                             |                          |                             | 29c. Licens                             |  |                                     |                           | e signed (Mor               | oth, Day, Year)                     | 2   |
|  |  |                                  | Man 6. Ul   | eur            | WE                            |                          |                             | 1004                                    | 6049                                     |                                     | Mar                       | ch L                        | 1 / 6008                            | ,   |
| 10   |  |                                  | 20. Name and address of person  | 1              |                               | death (Item              | n 23a) (Type,               | D04<br>Oprer 1                          | Moulh                                    | カレー                                 | MI                        | 22                          | 772                                 |     |
|  | State  |                                  | 31. Date filed (Month, Day, Year)   | palo           | 32. Regis                     | strar's Signa            | are                         |   | VICE                                     | 0-0                                 | A - C V                   | , – –                       |                                     |     |
| Reg  | istra  |                                  | MAR 2 8 2008  | Rose           |                               | y A                      | MAR.                        |   |  |                                     |                           |                             |                                     |     |

State of Maryland / Department of Health and Mental Hygiene Kwame Travon Johnson Certificate of Death 1- For State Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2325 hrs March 16, 2008 Kwame Travon Johnson cal Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 1368 Tyler Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign **Funeral** Davs Hours Min Months couMmaryland 21 1990 Mar Director 214-29-1422 1X M 2 F 17 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 1X Yes 2 No Anne Arundel Maryland Annapolis or 28a-f show or items 23a or 28a-f show must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 2012 Forest Dr. ō 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes Black Specify: Yes 2 X No specify: If Yes, Give Year 3 Widowed 4 Divorced 6b. Kind of Business/Industry Annapolis Senior 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) High School is marked other than 'atic event, the Medical Student 21215-0036 11th 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chrystal McGowan Damon V. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 21401 Annapolis, Md. Baltimore, MD Chrystal McGowan (Mother) 2012 Forest Dr. 20c. Location - City or Town, State Date 20b. Pace of Dispositor Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3-24-08 Annapolis, Md. Memorial Park permit. Pages
Department of
Important: I Donation 5 Other Specify: 22 Pean + Besceraty ons Vortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part I. Heter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical a. Gunshot wound of torso Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed g **AMENDED** LINPENDED attending physician or use as the burial /sician/Medi 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown ≥ 24b. Were autopsy findings available Completed 24a. Was an Records, certificate has been ector, page 2 should prior to completion of cause of autopsy death? performed? No ✓ Yes 2 No 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Division of Vital Other: A Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury FOUND: 28b. Time of Injury After 27. Manner of Death Subject shot Certification: FOUND: Yes 2 V No 1 Natural Pending within 24 hours after death.

To the Funeral Director: Director: 2321 hrs Mar 16, 2008 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1368 Tyler Avenue, Annapolis, MD Could not be 3 Suicide determined (Specify) Sidewalk 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Wedical Examiner:On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie March 17, 2008 O.C.M.E. eno 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. strar's Signature 31. Date filed (Month, Day, Year) State 25 2008 Registra

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

|                   |   |                     | 1 - For<br>State<br>Registrar  |   | State of M  | larylan                              |  |  | nt of H<br>te of L        |   |                         |                                      | Reg. No              | 211               | 08                      | 11760  |
|-------------------|---|---------------------|--|---|---|--------------------------------------|--|--|---------------------------|---|-------------------------|--------------------------------------|----------------------|-------------------|-------------------------|--|
| *                 | Physici<br>/Medic   |                     | 1. Decedent's Name   |   | <sub>st)</sub><br>Corinthia   |                                      | Jones                                  |  |                           |   |                         | . Date of De<br>Month<br>March 2     | Da                   | 08                | Year                    | 3. Time of Death 2:30 P M                              |
|                   | Examir  |                     | 4a. Facility Name (If 13012 Venar  | _   | e street and number   | )                                    |  |  |                           | Location of<br>ington                     | Death                   |                                      |                      |                   | of Death                | ge <b>'</b> s  |
|                   | Funeral<br>Director   |                     | 5. Social Security N<br>156–28–9118  | 3   | Sex 7. A  | ige (In yrs.<br>68                   | last birthday)<br>Yrs.                 | If Und<br>Months   | er1 Year<br>Days          | If Under 24<br>Hours                      | Min. S                  | Date of Bird<br>(Month Da<br>Pt. 10  | th<br>y, Year<br>193 | 9                 | 9. Birthp<br>Cour       | olace <i>(State or Foreign</i><br>otry) Virginia       |
|                   | yland<br>row<br>at  |                     | Usual Residence of<br>10a. State   | 10b. County   |   | 10c. Cit                             | y, Town or Lo                          | cation   |                           |   |                         |                                      |                      |                   | 1                       | 0d. Inside City Limits                                 |
|                   | e Mar<br>8a-f sh<br>ptified   | ctor                |  | Prince Geo  | rge's   | Ft.                                  | Washing                                |  |                           |   |                         |                                      |                      |                   |                         | 1 □ Yes 2 KNo  |
|                   | h with the sa or 2 st be no   | al Dire             | 10e. Street and Nur<br>13012 Venar   |   |   |                                      |  |  | ip Code<br>0744           |   |                         |                                      | -                    | tizen of \<br>USA | What Cour               | ntry?  |
| 980               | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Marri 3 □ Widowed   | ed 2∏ Married<br>4 X Divorced                             | 12. Was Deceden<br>Armed Forces<br>1 ☐ Yes 2 K<br>If Yes, Give<br>Year or Dates | ?<br>] No                            |  |  | 37                        | ispanic Origi<br>in, Mexican,<br>Specify: | in? (Speci<br>Puerto Ri | fy Yes or No<br>can, etc.)           | -                    |                   | ck, White,              |  |
| 21215-0036        | I within 72 ho<br>jiene.<br>r than "natur<br>the Medical I  | Completed           | (Spec  | 15. Decedent's E-<br>ify only highest gra<br>ndary (0-12) | ducation<br>ade completed)<br>5+ College (1-4or                                 | 5+)                                  | 16a. Dece<br>(Give<br>life.<br>Regist  | kind of w<br>DO NOT  | ork done d<br>use retired | ation<br>during most (<br>)               | of working              |                                      |                      | ind of Bi         | usiness/ind             | dustry   |
| Maryland 2        | 12 should be filed within "h and Mental Hygiene." Is marked other than "traumatic event, the Mec  | To Be C             | 17. Father's Name (<br>Earl Par  | First, Middle, Last<br>rker                               | )   |                                      |  |  |                           | 18. Mother                                |                         | <sup>First, Middle,</sup><br>gleston |                      | Surnan            | ne)                     |  |
| Mary              | d 2 sho   | ľ                   | 19a. Informant's Na  | nme/Relationship (  | Type. Print)  |                                      |  | -  |                           |   |                         | Route Numb<br>eorgia                 | -                    |                   | State, Zip              | Code)  |
| dî.               | permit. Pages 1 and 2<br>Department of Health<br>Important: If item 27 I<br>any Injury or other tra<br>once.  |                     | 20a. Method of Disp  | osition   | Removal from State  |                                      | Place of Dispo<br>cemetery, creatern l | sition (Name of the last of th | ame of<br>otherplac       | e)  | Dai<br>3/29/2           | te                                   | 20c. L               | ocation -         | City or To              |  |
| Baltir            | permit. Pages 1<br>Department of H<br>Important: If ite<br>any Injury or ot   |                     | 21. Signature of Fu  | neral Service Lice  |   | 9.2.2                                | 22                                     | 2. Name  | and Addres                | ss of Facility                            | Geor                    | ge P. K<br>Hill,                     | alas                 | Fune              |                         | me P.A.  |
| ų.                | Physician   |                     | shock, or hea<br>Immediate Cause (<br>disease or condition   | rt failure. List only<br>Final                            | oplications that cause<br>one cause on each<br>CE                               | line.                                | h. Do not en                           |  |                           |   | cardiac or              | respiratory a                        | rrest,               |                   |                         | Approximate<br>Interval Between<br>Onset and Death     |
|                   | /Medical<br>Examiner  |                     | resulting in death)  |   | Due to (or a  | s a conseq                           | uence of):                             |  |                           |   |                         |                                      |                      |                   |                         |  |
| 68760,            | icate be executed physician and sthe burial-transit   | al Examiner         | Sequentially list cor<br>if any, leading to im<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) L | -   | cDue to (or a   |                                      |  |  |                           |   |                         |                                      |                      |                   |                         |  |
| P.O. Box 687      | The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit   | Physician/Medical   | IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown  | months?   | 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown                           | 2 ☐ Feta<br>at time of d             | aldeath 3□                             | ⊒Ectopic<br>⊒ Other (  | pregnancy<br>specify)     | ,   |                         |                                      |                      |                   | te of delive            | ery<br>Day Year  |
|                   | quires that<br>n signed by  | by                  | Part II. Other signif  | lcant conditions  | contributing to death   | but not res                          | ulting in the u                        | nderlying  | cause give                | en in Part I.                             |                         |                                      |                      |                   |                         | ne cause of death?<br>pably 4 Unknown                  |
| or Vital Records, | (0)   | Completed           |  |   |   |                                      |  |  |                           |   |                         | 24a. Was<br>auto<br>perfo            |                      |                   | prior to co<br>death?   | psy findings available<br>mpletion of cause of<br>2 No |
| Vita              | Physician:<br>this certific   | Be                  | 25. Was case reference examiner?   |   | Hospital:   |                                      | ISB/0-1                                |  | Othe                      | 0.81                                      |                         | Check only o                         |                      |                   |                         |  |
| on or             | ding Phy<br>n.<br>After this<br>funeral d   | tion: To            | 1 ☐ Yes 2 ☐  27. Manner of Deatl  1 ☑ Matura!  2 ☐ Accident  |   | 28a. Date of In<br>(Month, D  | jury                                 | 28b. Time o<br>Injury                  |  | 28c. Injur                | 4 🗀 Nurs                                  | 28                      | d. Describe                          |                      |                   |                         | <sup>(y)</sup>   |
| Division          | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.   | Certification:      | 3 Suicide 4 Homicide   | 6 Could not b   | e 28e. Place of in  | njury - At ho<br>etc. <i>(Specil</i> | ome, farm, str<br>(y)                  | eet, facto   |                           |   |                         | f. Location (<br>City or To          |                      |                   | per or Rura             | al Route Number,                                       |
|                   | To the Hospital within 24 hours a To the Funeral completely filled  | Medical C           | 29a. Certifier<br>(Check only<br>one)  | 1 Certifying Pl   | nysician: To the bes<br>miner: On the basis<br>and manners                      | of examina                           | owledge, deat<br>ation and/or in       | h occurre  | ed at the tin             | ne, date and<br>pinion, deat              | d place, ar             | d due to the<br>d at the time,       | cause(s              | s) and made,      | anner as s<br>and due t | tated.<br>o the cause(s)                               |
|                   | To the Comple   | Med                 | 29b. Signature and   | title of continer   |   |                                      |  | 2  | 9c. Licenso               | e number<br>46285                         |                         |                                      |                      |                   | 25,                     | Day, Year)<br>2008                                     |
| R                 | (12)  |                     | 30. Name and addr<br>Paul Bo   | ess of person who   | completed cause of 10905 Ft.  | death (Iten                          | n 23a) (Type,<br>ningtor               | Print)<br>1 Roa  | ıd #2                     | 206 Ft                                    | . Was                   | shingt                               | on,                  | Mar               | y1and                   | 20744  |
| 7                 | Sta   | ate                 | 31. Date filed (Mon  |   | 32. Regis   | trar's Signa                         | ature                                  |  |                           |   |                         |                                      |                      |                   |                         |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 19Day 2008ar 12:50 PM Doretha Jones /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Temple Hills 2908 Kernal Lane Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√2 F Months Days Hours Min 245-82-3411 88 Director Franklin Co.N.C 1919 May 02 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov tra Medical Evanther πuel be notified 1∏Yes 2 ☐ No Directo Prince George's Maryland Temp1e Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2908 Kernal Lane States United 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Maker Private marked other Alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Rella Mitchell . Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Brooks-Daughter 2908 Kernal Lane, Temple Hills, Maryland 20748 Linda Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 ☐ Cremation 3 B Removal from State Gethsemane Bapt.Cem. 3/26/2008 4 ☐ Donation 5 ☐ Other (Specify) BUNN, North Carolina permit. ire of Funeral Service Li e see 22. Name and Address of Facility Pope Funeral Home 5538 Marlboro Pike Forestville Md 20747 Pact. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner de of) Due to (or as a conseque The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 🖾 No the o 9 Unknown s been signed by the should be detached 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🙀 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 CxCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the ca 29a. Certifier Medical completely (Check only nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

REDJAEE, MD BAHRAM

4467 Old Branch AVE., Suite #201 Temple Hills, Maryland 20748

31. Date filed (Month, Day, Year) 32. Registrar's Signa MAR 2 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** KING-24 2008 10 ERRY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TAKOMA PARK MONTOURN WASHINGTON ADVENDST HUSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□F Months Days 215-38-6694 Director 67 08/07/40 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show be notified at MD PRINCE GEORGES 1√2 Yes 2 □ No RIVERDALE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 6512 51ST AVENUE 20737 **Examiner must** Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ BLACK 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR PRIVATE 10TH permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ WILLIAM JACKSON MABLE KING ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERIDA JONES/DAUGHTER 6512 51ST AVENUE RIVERDALE, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 03/28/2008 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** THEROSCIEROTU CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate death? 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 📈¥es 2 🔲 No 1 🔲 Inpatient 2ÆR/Outpatient 3□ DOA ပ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Tothe Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60319

State

31. Date filed (Month, Day, Year) MAR 2 8 2008

7600 CARROLL AVENUE TAKOMA PARK, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Hospital or Attending Physician;

within 24 hou **To the Fune** completely file Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Devore, M.D. 4203 Queensbury Rd., Hyattsville, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 8 2008

Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

March 28,2008

amend 21,22 per hosp. g878 4/10/08 KH
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

|  | Certificate of Death   |
|--|--|
| Physician  | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day, Year   |
| /Medical<br>Examiner   | Marc Alexander Monzon  4a Fecility Name (If not institution, give street end number).  4b. City, Town, or Location of Death  4c. County of Death   |
| Examiner   | Prince George's Hospital Center Cheverly Prince George's   |
| Funeral<br>Director  | 5. Social Security Number  6. Sex 1  |
| ith the Maryland<br>or 28a-1 show<br>e notified at   | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD Prince George's Temple Hills 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |
| th with the 23a or 23a are 25a | 10e. Street end Number  4114 24 Place  10f. Zip Code  207 48  10g. Citizen of What Country?  United States   |
| Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mentel hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director  | 11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married 3 Nidowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes 2 No Specify: 4 Armed Forces  1 Yes 2 No Specify: 4 Armed Forces  14. Race - American Indian, Black, White, etc.  14. Race - American Indian, Black, White, etc.   |
| 2 hour   | 15 Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business/Industry  |
| yland 21215-0020<br>uld be filed within 72 hours eff<br>Wentel Hygiene.<br>riked other then "naturel", or<br>ritic event, the Medical Exer-<br>TO Be Completed by F  | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)  Lofant  |
| d 212<br>filed with<br>Hygiene<br>with the   | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  |
| larylan 2 should be end Mentel en merked o summit eve  | Julio Cesar Monzon April Adrianna Germosen   |
| , Maryland and 2 should be file self should be file self self self self self self self se  | 19a. Informant's Name/Relationship (Type, Print)  Mother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  414 24 <sup>th</sup> Place, Temple, Hulls MD 20748  |
| Baltimore, semi: Pages 1 ar Depertment of Hee mportant: If item introlutry or other ance.  | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State   |
| Baltimo<br>permit. Pag<br>Dependent<br>important: I<br>any Injury o  | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Prince George's Hospital Center 3001 Hospital DR. Cheverly, MD 20785   |
|  | 23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)  a. Post ir a tory Distress Syndrome  a. Post ir a tory Distress Syndrome  pue to (or es e consequence/of):  |
| Box 68760,<br>eath certificate be assouted<br>attending physician and<br>for use as the burial-transit<br>claryMedical Examiner  | Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last  b. Mutti be Congress to Congr |
| death cer death cer le attendin ed for usa   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death?   |
| IS, P.O. BOX as that the death cer gined by the attendin be detached for usa by Physician/N  | 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown  |
| cord require   | 24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  |
| Re(  | 1 Pres 2UNu 1 UYes 2UNo  |
| Vital Riclen: The I certificate har rector, pege   | 25. Was case referred to medical examiner? 26. Place of Death (Check only one)   |
| # 5 85 F   | Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)  |
| ion<br>nding lath.<br>r: After<br>e fune   | 27. Menner of Death    Natural 5   Pending (Month, Dey Year)   28b. Time of Injury   28c. Injury at Work?   28c. Injury at Work?   1   Yes 2   No  |
| Division of all or Attending Physics after deeth. I Director: After this de in by the funerel deciritions of the Certification: To   | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)  |
| Division C To the Hospital or Attending PI within 24 hours after deeth. To the Funeral Director: After it completely filled in by the funeral Medical Certification:   | 29a. Certifier (Check only one)  1D Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted.  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.  |
| To the within 2 To the comple  | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  29d. Date signed (Month, Day, Yeer)   |
| KB.X   | 30. Name and address of person who completed cause of deeth them 23e) (Type, Print)  ANTOINE K TO MUTOR MD 3001 Hospital Dive, Chevely, Md. 203  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)  MAR 2 6 2008  32. Registrer's Signature   |

|     | 2284<br>elle Summe   |                   | Please Type or Print in Black Indelible In State of Maryland / Department of Please Type or Print in Black Indelible In State of Maryland / Department of Certificate of | f Health and Mental Hygiene  | gible.<br>2008 1177   |
|-----|--|-------------------|--|--|---|
|     | Physici  |                   |  | 2. Date of Dea   | ath 3. Time of Death  |
| Med | tical Exami  |                   |  | 4b. City, Town, or Location of Death Fort Washington   | 2350 hrs 4c. County of Death Prince George's                                  |
|     | Funeral  | -                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  |  | rth(MM/DD/YYYY) 9. Birthplace (State or                                       |
|     | Director   |                   | 578-80-4816 1 M 2 F 49 Yrs   | Marilla I Day at 11 and 1 and  | 0/1959 Foreign<br>Country) DC   |
|     | any  | 1                 | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat   | tion   | 10d. Inside City Limits   |
|     | nd<br>Show :   | ے                 | MD PG Oxon Hi  | i11  | 1 <sub>X</sub> Yes 2 No   |
|     | Aaryla<br>28a-f:<br>I at or  | Director          | 10e. Street and Number   |  | 10g. Citizen of What Country?   |
|     | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. |                   |  | 20745  | U.S.A   |
|     | ath wir  | Funeral           | 11. Marital Status  12. Was Decedent Ever in U.S. 13. Was In Marital Status  14. Marital Status  15. Was Decedent Ever in U.S.  16. Year Married In Marital Status       | as Decedent of Hispanic Origin? (Specify Yes or No<br>Yes, specify Cuban, Mexican, Puerto Rican, etc.) | o- 14. Race - American Indian, Black, White, etc.                             |
|     | fter de:<br> ", or i   |                   |  | Yes 2 No specify:  | Specify: Black  |
|     | ours at<br>atural  | d by              | l or Dates:  | nt's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)                | 16b. Kind of Business/Industry  |
|     | n 72 h   | Completed         | Elementary/Secondary (0-12) College (1-4 or 5+)  10 Adn  | ministrative Asst.   | DC Parks & Rec:   |
|     | -003<br>I withi<br>giene.<br>ther the  | E O               | 17. Father's Name (First, Middle, Last)  | 18.Mother's Name (First, Middle,   | Recreation  |
|     | 215.<br>De filec<br>ntal Hy<br>rked of   | BeC               |  | Shirley F.   | ,   |
|     | 21<br>nould 1<br>id Mer<br>is mar  | 은                 | 19a. Informant's Name/Relationship (Type, Print )  | ng Address (Street and Number or Rural Route Nu  |   |
|     | MC 2 sl<br>alth ar<br>an 27  |                   |  | 5 Leyte Dr. Oxon Hil   | 1, MD 20/45<br>20c. Location - City or Town, State                            |
|     | Ore<br>ges 1 a<br>t of He<br>t I it  |                   | 1 X Burial 2 Cremation 3 Removal from State crematory or ot  | ther place)  |   |
|     | Itim<br>it. Pag<br>rtment<br>rtant:<br>y or o  |                   |  | n Cemetery 4/1/08  | Suitland, MD<br>and Funeral Services  |
|     | Ba<br>perm<br>Depa<br>fmpc<br>imjur  | d                 |  | 500 Allentown Rd. Ca   |   |
|     | Physician  |                   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.  | the mode of dying, such as cardiac or respiratory ar   | rrest, shock, or heart Approximate Interval Between Onset and                 |
| 4   | /Medical<br>xaminer  |                   | Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card  | liovascular Disease  | Death   |
|     |  |                   | or condition resulting in death)  Due to (or as a consequence of):  b.   |  |   |
|     |  | ē                 | Sequentially list conditions.  |  |   |
|     |  | xaminer           | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |  |   |
|     | cuted<br>nd<br>transit   | w l               | d  |  |   |
|     | ),<br>be exer<br>ician a<br>irial - i  | dica              | UNPENDED AMENDED   |  |   |
|     | Box 68760, death certificate be executed the attending physician and ed for use as the burial - transit  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the 2 3c. If yes, outcome of pregnancy 1 Live birth 2 Fe  | etal death 3 Ectopic pregnancy   | 23d. Date of delivery  Month Day Year   |
|     | x 68<br>h certi<br>tendin<br>use as  | iciaı             | past 12 months?  1 Live birth 2 Fe 4 Pregnant at time of death 5 O   | etal death 3 Ectopic pregnancy other (Specify)   | Month Bay real  |
|     | Bo<br>ne deat<br>the at<br>hed for   | hys               | 1 Yes 2 No 9 V Unknown 9 Unknown   | 200 - 100  |   |
|     | P.O.   | 2                 | Diahetes   | underlying cause given in Part I. 23e. Did   | tobacco use contribute to the cause of death?  es 2 No 3 Probably 4 V Unknown |
|     | ords,<br>w require<br>us been sig<br>should be   | Completed         | Diabotes   | 24a. Was   |   |
|     | COF<br>e law r<br>e has b  | du                |  |  | ormed? death?   |
|     | Vital Rec<br>ysician: The I<br>his certificate I<br>director, page   |                   |  | 26.Place of Death (Check only one)   | 2 No 1 Yes 2 No   |
|     | Vita<br>ysicia<br>his cer<br>direct  | To Be             | examiner? Hospital:  | Othor  | Residence 6 Other:  |
|     |  |                   |  |  | e how injury occurred   |
|     | IVISION or Attendi after death. Director:  | catic             | Pending  Accident Investigation  | 1 Yes 2 No   | (Otract and Number 12) at 2   |
|     | Division of To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After I completely filled in by the funeral   | Certification:    | 3 Suicide 6 Could not be determined (Specify)  | eet, factory, office building, etc. 28f. Location or Town,   | (Street and Number or Rural Route Number, City State)                         |
|     | Hospital<br>24 hours<br>Funeral<br>tely fillec   |                   |  | urred at the time, date and place, and due to the car  | use(s) and manner as stated.  |
|     | To the within 2 To the I   | Medical           | one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.  |  |   |
|     | >->  | - ≝ 1             | 29h Signature and title of certifier   | 29c. License number  | 29d, Date signed (Month, Day Year)  |





30. Name and address of person who completed cause of death (Item 23a)

Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day Year)



O.C.M.E.

March 23, 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|             |   |                | For State Registrar   | State                                | of Mar                                | yland       |                              | artment o   |                              |                       | nd Mei                 | -                       | giene<br>Reg. No.    | 2111                 | 8        | -                            | 774                   |
|-------------|---|----------------|---|--------------------------------------|---------------------------------------|-------------|------------------------------|---|------------------------------|-----------------------|------------------------|-------------------------|----------------------|----------------------|----------|------------------------------|-----------------------|
| 1           | p &   |                | 1. Decedent's Name (First, Middle,  | Last)                                |                                       |             |                              |   |                              |                       | 2.                     | Date of De<br>Month     |                      |                      | ear      | 3. Time o                    | of Death              |
|             | Physici<br>/Medio   |                | CLARA MCELROY   |                                      |                                       |             |                              |   |                              |                       | M                      | ARCH                    |                      |                      | aı       | 7:45                         | A M                   |
|             | Examin  | er             | 4a. Facility Name (If not institution, g  |                                      | ımber)                                |             |                              | 4b. City, Tow                                       | n, or Loc                    | ation of [            | Death                  |                         |                      | County of [          |          |                              |                       |
| _           |   | 2              | 13308 YORKTOWN  5. Social Security Number 6   | . Sex                                | 7. Age (                              | (In vrs. la | ast birthday)                | BOWIE  If Under 1 Y                                 | ear Ift                      | Under 24              | 4 Hrs. 8               | Date of Birl            |                      | INCE                 |          |                              | or Foreign            |
| и           | Funeral Director  |                | 427-40-9626   | 1□M 2፟MF                             |                                       | 94          | Yrs.                         | Months Da   |                              |                       | Min.                   | (Month, Da<br>3/12/     | y, Year)             | M                    | Cour     | lace (State<br>try)<br>ISSIP | PT                    |
| 24          | pt _  |                | Usual Residence of Decedent   |                                      |                                       |             |                              |   |                              |                       |                        | 3/12/                   |                      |                      |          |                              |                       |
|             | anylar<br>show  | <u>_</u>       | MD 10b. County PRINCE   | GEORGES                              | 1                                     | BOW         | , Town or Lo<br>JTF.         | ecation   |                              |                       |                        |                         |                      |                      | 1        | 0d. Inside C                 | City Limits<br>2 ☐ No |
|             | the M<br>28a-f  | Director       | 10e. Street and Number  |                                      |                                       | 201         |                              | 10f. Zip Coo  | 4.                           |                       |                        |                         | 10- 04               |                      |          |                              |                       |
|             | with with the r   | ā              | 13308 YORKTOWN  | DRIVE                                |                                       |             |                              | 2071  |                              |                       |                        |                         | USA                  | zen of Wha           | Coun     | itry ?                       |                       |
|             | hours after death with the Maryland<br>tural", or Items 23a or 28a-f show<br>al Examiner must be notified at  | Funeral        | 11. Marital Status  | 12. Was Dec                          | edent Eve                             | er in U.S   | 3. 13.                       | Was Decedent  |                              | nic Origin            | n? (Specify            | y Yes or No             |                      | 14. Race - /         |          |                              |                       |
| 9           | or Ite  |                | 1 ☐ Never Married 2 ☐ Married   | Armed F<br>1 ☐ Yes<br>If Yes, G      | 2X No                                 |             | - 1                          | If Yes, specify (<br>1 ☐ Yes 2 <b>X</b> O           |                              | lexican, f<br>oecify: | Puerto Ric             | an, etc.)               | -                    | Black, V             |          |                              |                       |
| 21215-0036  | ural",  | d by           | 3 ☐ Widowed 4 📉 Divorced  | Year or I                            |                                       |             |                              |   |                              |                       |                        |                         |                      | Specify:             |          |                              |                       |
| 7           | "nati   | Completed      | 15. Decedent's<br>(Specify only highest)  | Education<br>grade completed,        |                                       |             | 16a. Dece<br>(Give           | dent's Usual Oo<br>kind of work do<br>DO NOT use re | cupation<br>one during       | i<br>g most o         | of working             |                         | 16b. Ki              | nd of Busin          | ess/Ind  | dustry                       |                       |
| 717         | withi   | ошо            | Elementary/Secondary (0-12) 7TH   | College                              | 1-4or 5+)                             |             | CUSTO                        | DIAN  |                              |                       |                        | :                       | PRI                  | VATE                 |          |                              |                       |
|             | ould be filed within 72 hours after death with the Marylar Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show arked other than "natural", or Items 23a or 28a-f show atic event, the Medical Examiner must be notified at | BeC            | 17. Father's Name (First, Middle, La  | st)                                  |                                       |             |                              |   | 18.                          | Mother's              | s Name (F              | irst, Middle,           | Maiden               | Surname)             |          |                              |                       |
| Ma          | should b<br>and Ments<br>marked<br>umatic e   | To E           | HOSIE MCATEE  |                                      |                                       |             |                              |   | MA                           | RY H                  | HAYNE                  | S                       |                      |                      |          |                              |                       |
| Maryland    | 2 sh<br>and<br>ls m   | 1 7/           | 19a. Informant's Name/Relationship  | , , ,                                |                                       | - /         | 19b. Mailii                  | ng Address (Sti                                     | eet and I                    | Number (              | or Rural R             | loute Numb              | er, City o           | r Town, Sta          | te, Zip  | Code)                        |                       |
| _           | 1 and<br>Health<br>em 27<br>ither tu  |                | FRED HARMON/SON 20a. Method of Disposition  |                                      |                                       | 20b. Pla    | 13308                        | YORKTO  | WN D                         | RIVE                  | E BOW<br>Date          |                         |                      | 715<br>cation - City | or To    | wn State                     |                       |
| ğ           | D = 0   |                | 1 XBurial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe  |                                      | State                                 |             |                              | sition (Name o<br>matory or other<br>EMORIAL        |                              | 0.3                   |                        | 2008                    |                      |                      |          |                              | орт                   |
| altimore,   |   |                | 21. Signature of Funeral Service Lic  | - 1                                  |                                       | 1101        |                              | 2. Name and A                                       |                              |                       |                        |                         |                      |                      |          |                              | FI                    |
| ñ           | permit. Departi Importi any Inj   | 18             | > maying  | dewo                                 |                                       |             | 7                            | 474 LAN   | DOVE                         | R RO                  | DAD L                  | ANDOVI                  | ER, 1                | MD 207               | 785      |                              |                       |
| H           |   |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on  | emplications that<br>ly one cause on | caused th                             | ie death.   | . Do not ent                 | er the mode of                                      | dying, su                    | ich as ca             | ardiac or re           | espiratory ar           | rrest,               |                      |          | Approxima<br>Interval Be     | ite<br>etween         |
| 3           | Physician   |                | Immediate Cause (Final disease or condition   |                                      |                                       |             |                              | ARRYTH  |                              |                       |                        |                         |                      |                      |          | Onset and                    | Death                 |
| 18          | /Medical<br>Examiner  |                | resulting in death)   |                                      | (or as a c                            |             |                              |   |                              |                       |                        |                         |                      | _                    |          |                              |                       |
|             |   | er             | Sequentially list conditions,   | b                                    | (or as a c                            |             |                              |   |                              |                       |                        |                         |                      |                      |          |                              |                       |
|             | uted<br>d<br>ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                      | ,                                     |             | ,                            |   |                              |                       |                        |                         |                      |                      |          |                              |                       |
| o,          | an an   |                | resulting in death) Last  | Due to                               | (or as a c                            | conseque    | ence of):                    |   |                              |                       |                        |                         |                      |                      |          |                              |                       |
| 8/60,       | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit  | dical          |   | d                                    |                                       |             |                              |   |                              |                       |                        |                         |                      |                      | 4        |                              |                       |
| õ<br>×      | ertific<br>ling p   | Mec            | IF FEMALE:  | 00- 16                               |                                       |             |                              |   |                              |                       |                        |                         |                      |                      |          |                              |                       |
| Z<br>D<br>D | eath c<br>attenc<br>for us  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   |                                      | itcome pr<br>birth 2 [<br>nant at tin | Fetal       | death 3[                     | Ectopic pregna<br>Other (specify                    |                              |                       |                        |                         | 2                    | 3d. Date of<br>Month | delive   | ry<br>Day                    | Year                  |
| j.          | the de  | ıysic          | 1 ☐ Yes 2 <b>XX</b> No<br>9 ☐ Unknown   | 9☐Unkr                               |                                       | ne or de    | atii 5L                      | _Other (specii)                                     | "——                          |                       |                        |                         |                      |                      |          |                              |                       |
| ν,<br>Τ     | w requires that the de<br>been signed by the<br>should be detached  | by Pt          | Part II. Other significant conditions   | contributing to                      | leath but r                           | not result  | lting in the u               | nderlying cause                                     | given in                     | Part I.               |                        | 23e. Did to             | obacco u             | se contribu          | te to th | e cause of                   | death?                |
| Hecords     | en sig  |                | ***   |                                      |                                       |             |                              |   |                              |                       | _ 1                    | 1 🗆 1                   | res 2                | No 3                 | Prob     | abiy 4 🗌                     | Unknown               |
| ပ္သ         | as be<br>2 sho  | Completed      |   |                                      |                                       |             |                              |   |                              |                       | 1                      | 24a. Was                |                      | 24b. Wer             | e auto   | psy findings                 | available             |
| =           | The laste has   | Som            |   |                                      |                                       |             |                              |   |                              |                       |                        | perfo                   | rmed?                | deat                 | h?       | 2 No                         | Jause OI              |
| N Eal       | Physician: The law<br>this certificate has braidirector, page 2 s   | Be             | 25. Was case referred to medical examiner?  | Hospital:                            |                                       |             |                              | 1   | 041                          |                       |                        | heck only o             |                      |                      |          |                              |                       |
| 5           | Phys  | ٠ <u>۲</u>     | 1 ☐ Yes 2 ☐ No  27. Manner of Death   | 28a. Date                            | Inpatient<br>of Injury                |             | R/Outpatier<br>28b. Time o   | " OLI DOA   |                              | □ Nursi               |                        | 5 🕅 Resid               |                      |                      | Specify  | /)                           |                       |
| 0           | ding<br>th.<br>: After<br>s fune  | tion           | Natural 5 Pending 2 Accident investigati  | (Moi                                 | ith, Day Y                            |             | Injury                       |   | njury at<br>Work?<br>1 ☐ Yes | 2 🗆 No                |                        | . Describe r            | iow injury           | / occurred           |          |                              |                       |
| UNISION     | Atter<br>r dear<br>ector<br>by the  | ifica          | 3 ☐ Suicide 6 ☐ Could not determine   | be 28e. Place                        | of injury                             | - At hom    | ne, farm, str                | eet, factory, off                                   | ice                          |                       | 28f.                   | Location (5             | Street and           | d Number o           | r Rura   | l Route Nur                  | nber,                 |
| 5           | tal or  | Certification: | 4 Difference  | build                                | ilig, etc. (                          | ореспу)     |                              |   |                              |                       |                        | City or Tou             | vn, State,           |                      |          |                              |                       |
|             | To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,  | edical         | (Check only 2 ☐ Medical Ex  | Physician: To th<br>aminer: On the I | asis of ex                            | xaminatio   | rledge, deat<br>on and/or in | n occurred at th                                    | ie time, d<br>ny opinio      | ate and p             | place, and<br>occurred | due to the at the time. | cause(s)<br>date and | and manne            | r as st  | ated.                        | s)                    |
|             | thin 2<br>the I   | Medi           | 29b. Signature and title of certifier   | and mar                              | ner stated                            | d.          | 1                            |   | ense nur                     |                       |                        |                         |                      | e sined (M           |          |                              |                       |
|             | F 3 F 8   |                | Da  | Dil                                  | 4                                     |             | 1                            |   | 6665                         |                       |                        |                         | 0                    | 2 2                  | 5        | 700                          | 36                    |
| ,           | 0   |                | 30. Name and address of person wh   | o completed cau                      | se of deat                            | th (Item 2  | 23a) (Type.                  | Print)  | _                            |                       |                        |                         |                      | 10                   | 1        | 201                          | 2                     |
| 1           | 00  |                | REXFORD BABILAH   | M.D. 7                               | 500 I                                 | HANO        | VER PA                       | ,   | #101                         | A_GR                  | EENBF                  | ELT. M                  | ID 20                | 770                  |          |                              |                       |
|             | Sta<br>Registr  | -              | 31. Date filed (Month, Day, Year) MAR 2 6 2008  | 32.1                                 | Registrar's                           | Signat      | re                           |   |                              |                       |                        |                         |                      |                      |          |                              |                       |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) MARCI Par MORRIS Physician ARY 2320 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Hospice of the Chesapeake Linthicum If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 2 XF 60 236-76-1946 Jan. 1948 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a, State 10b. County 1 XYes 2 No Director Maryland | Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be USA 1833 Harewood Lane 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 XDivorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. Real Estate Acquisition Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked of traumatic even Rennie Merdeath Earl Brewer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau 1833 Harewood Lane Crofton, MD 21114 Shane Morris/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory 3, 22. Name and Address of Facility 3/21/2008\_ | Alexandria, VA 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home pe 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 25 No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has e 2 certificate ha Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Bother (Specify) HOS PICE Other: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient P this After thi funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation M 1 ☐ Yes 2 ☐ No neral Director: , filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) MAR 2 5 2008 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Margaret McNulty 6:30 P M 2008 2.7 /Medical MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester 5. Social Securify Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Months Days Hours 216-14-8219 83 6/7/1924 Director MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10504 Brighton Rd. 21842 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Giant Food permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius O'Leary Mabel McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 114 7th Ave., Baltimore, MD 21225 Joseph McNulty / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/29/2008 Frankford, DE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature Funeral Service License 108 William St., Berlin, MD 21811 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Enter the disease. Immediate Cause (Final disease or condition resulting in death) Cardiovascular **Physician** /Medical **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical SB IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Certification: To Be Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f

Division or Vital Records, P.O. Box 68760,

CNULTY MARY Itimore, Maryland 21215-0036

| Part II. Other significant conditions  Demen     | , · · ·                          | alting in the underlying    | cause given in Part I.  |                                       | se contribute to the cause of death?<br>☐ No 3 ☐ Probably 4 ☑ Unknown                      |  |  |  |
|--|----------------------------------|-----------------------------|---|---------------------------------------|--|--|--|--|
|  |                                  |                             |   | 24a. Was an autopsy performed? 1  Yes | 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |  |  |  |
| 25. Was case referred to medical                 | medical 26. Place of Death       |                             |   | ath (Check only one)                  | (Check only one)   |  |  |  |
| examiner?<br>1 Tes 2 No                          | Hospital: 1 ☐ Inpatient 2 ☐ E    | ER/Outpatient 3 ☐ [         | ome 5 ☐ Residence 6 ☐ Other (Specify)   |                                       |  |  |  |  |
| 27. Maryner of Death                             | (Month, Day Year)                | 28b. Time of<br>Injury<br>M | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                                       | 28d. Describe how injury              | y occurred   |  |  |  |
| 3 Suicide 6 Could not b<br>4 Homicide determined |                                  |                             | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                       |  |  |  |  |
| 29a. Certifier 17. Certifying P                  | hysician: To the best of my know | wledge, death occurre       | ed at the time, date and place  | e, and due to the cause(s)            | and manner as stated.  |  |  |  |

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BA5

Medical

31. Date filed (Month, Day, Year)

(Check only one)

29b. Sign

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Prir

MAR 2 8 2008

> D28769 3(2868)

29d. Date signed (Month, Day, Year)

3(2868)

29d. Date signed (Month, Day, Year)

3(2868)

29d. Date signed (Month, Day, Year)

3(2868)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 22,2008 Anne Lorna Ellis 5 AM Maghan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner South River Millennium Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Month Pay Year) 10728/1907 577-26-2805 Minnesota 100 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at MD Anne Arundel Shady Side 1 ☐ Yes ŽŽNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20764 1212 Hayes Rd. USA 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after Affiled Folces
1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2⊠No White 1 ☐ Yes 2 No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within ' Department of Health and Mental Hygiene. ' Important: If item 27 is marked other than ''i any Injury or other traumatic event, the Meo gonee. Elementary/Secondary (0-12) College (1-4or 5+) Director Day Nursery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Lee Ellis Lottie Mae Barker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Hayes Rd. Shady Side, MD Alice Chesler Daughter 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1¥38urial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 3/26/2008 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 77 Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD - ( 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Carellere /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 9☐Unknown Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ allura to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1∐ Yes 2 □No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☐ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide

Box 68760, P.O. | Division or Vital Records,

Saltimore, Maryland 21215-0036

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Avenue

#231

29b. Signature ar title of certifier

D

600

29c. License number 29d. Date signed (Month, Day, Year)

Annapolis

D57028 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

03-24-08

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 6 2008

Chopra

Ridoply gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 28, 2008 Physician Ola Fay MARKS 6:00 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Assisted Living Hagerstown Washington Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min 1 □ M 2 🕅 I 220-05-6043 89 Director 3, 1918 Maryland Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1158 Luther Drive 21740 USA filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 2**X** No 1 ☐ Yes 2 ♣No Specify <u>م</u> Specify: white 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th accounts payable clerk truck mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Peter Poffenburger Laura Nave 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura L. Snyder - daughter 9810 Sharpsburg Pike, Hagerstown, Md. 21740 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemeterv 3/31/08 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nosulendis Physician Bans /Medical to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar be execu Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated by the property of the property 3 ☐ Probably 1 ☐ Yes 2 ☐ No 4 **☑** Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes performe 1☐ Yes 2 □ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No P 1 ☐ Inpatient 15915160 2 ER/Outpatient 3 DOA this 6 Other (Specify, 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation A Hospital or Attendl 24 hours after death. E Funeral Director; A etely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D

12H-2

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Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division or Vital Records,

State Registrar

Medical

29a. Certifier

30. Name any

one)

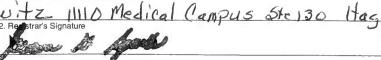
(Check only

29b. Signature and title of certifier

6

31. Date filed (Month, Day, 2008 MAR 3

of person v



Sica

o completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

|                     |  |                | For   | State of Maryla  |                                      |  |   | ∕lental Hyg                                  | iene  |   |
|---------------------|--|----------------|---|--|--------------------------------------|--|---|--|---|---|
|                     | 1 - State Registrar Certificate of Death Reg. No. 2  |                |   |  |                                      |  |   |  | 11779   |   |
| e                   | Physicia   | an l           | Decedent's Name (First, Middle, La  |  |                                      | 2. Date of Deat<br>Month<br>March              | Davi Vasa                                     |  |   |   |
|                     | /Medic   | _              | Richard L. Neal, Sr.  |  |                                      |  |   |  |   | 11:00 Рм  |
| )                   | Examin   | er             | 4a. Facility Name (If not institution, giv  |  |                                      |  | or Location of Death                          |  | Anne Arun   |   |
|                     |  |                | Anne Arundel Med 5. Social Security Number 6. S   |  | Annapo                               |  | 8. Date of Birth                              | Q Riet                                       | nplace (State or Foreign                          |   |
| Ä                   | Funeral Director   |                |   | 1XIM 2□F 80  | Yrs.                                 | Months Day                                     |   | 03/21/1                                      | Year) Co.   | Virginia  |
|                     |  |                | Usual Residence of Decedent   |  |                                      | l  |   | 05/21/1                                      | 721   | 1161111   |
|                     | ylanc<br>how<br>at   | .              | 10a. State 10b. County  | 10c.   | City, Town or Lo                     | ocation  |   |  |   | 10d. Inside City Limits                         |
|                     | e Ma<br>la-f s<br>tified   | 당              | Maryland Anne Ar  | undel H  | arwood                               |  |   |  |   | 1 □ Yes 2 No                                    |
|                     | or 28  | Director       | 10e. Street and Number  |  |                                      | 10f. Zip Code                                  |   | 1  | 0g. Citizen of What Co                            |   |
|                     | ath w  | ra<br>La       | 4775B Carmody Cou   |  |                                      | 20776  |   |  | United St   |   |
|                     | hours after death with the Maryland<br>tural", or Items 23a or 28a-f show<br>al Examiner must be notified at   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in Armed Forces?  1 Yes 2 No           | U.S. 13.                             | Was Decedent of<br>If Yes, specify Cu          | Hispanic Origin? (Sp<br>ban, Mexican, Puert   | pecify Yes or No-<br>p Rican, etc.)          | 14. Race - Amer<br>Black, White                   |   |
| 36                  | rs aft   | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                               |                                      | 1 □ Yes 2 🛣 N                                  | o Specify:                                    |  | Specify:  | hite  |
| ş                   | 2 hou<br>atura<br>cal E  | eq             | 15. Decedent's E  | ducation   |                                      | dent's Usual Occ                               |   | . I  | 16b. Kind of Business/l                           | ndustry   |
| 212                 | filed within 72<br>Hygiene.<br>Ither than "nai<br>Int, the Medics  | Completed      | (Specify only highest grant Elementary/Secondary (0-12)   | College (1-4or 5+)   | (Give                                | NOT use reti                                   | e during most of wor<br>red)                  | king   |   |   |
| 27                  | d wit  | Š              | 9   |  | Mecha                                | nic  |   |  | Automotive  |   |
| 2                   | be file<br>Ital Hy<br>Id oth   | Be (           | 17. Father's Name (First, Middle, Last  | •  |                                      |  | 1   |  | Maiden Surname)                                   |   |
| <u>ya</u>           | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at  | ပ္             | Jessie Newton Ne  |  |                                      |  | Estelli                                       |  |   |   |
| Maryland 21215-0036 | 2 sal  | - 6            | 19a. Informant's Name/Relationship  |  |                                      |  |   |  | r, City or Town, State, Z                         |   |
|                     | 1 and<br>Health  |                | Patricia D. Maus/   |  |                                      | Wartiel  | d Road, E                                     | <del></del>                                  | , Maryland 20c. Location - City or                |   |
| و                   | Pages<br>nent of l<br>int: If its<br>iry or o  |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐  | Removal from State   | cemetery, cre<br>alas Cr             | matory or other p                              |   |  | Edgewater,  |   |
| Baltimore,          | nit. Partme<br>artme<br>ortani<br>injury   |                | 4 □ Donation 5 □ Other (Speci   | .97  |                                      | •  |   |  | Kalas Funer                                       | •   |
| g                   | permit. Pages Department of I Important: If its any injury or of   |                | > /////////   |  |                                      |  |   | _  | dgewater, M                                       |   |
| -                   |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | nplications that caused the de                               |                                      |  |   |  |   | Approximate<br>Interval Between                 |
|                     | Physician  | a 4            | Immediate Cause (Final disease or condition   |  |                                      |  | leart 1                                       |  |   | Onset and Death                                 |
|                     | /Medical   |                | resulting in death)   | Due to (or as a cons   |                                      | 110 11   | - i   | 170/1  |   |   |
| E.                  | Examiner   |                | Sequentially list conditions.   | 1 19stol   | ic H                                 | eart t   | alure   |  |   |   |
|                     | p #is  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a cons   | equence of):                         |  |   |  |   |   |
| _                   | and<br>I-tran  | хап            | that initiated events<br>resulting in death) Last   | c<br>Due to (or as a cons                                    | equence of):                         |  |   |  |   |   |
| 8760                | ificate be executed<br>g physician and<br>as the burial-transit  |                | l l   | ,  |                                      |  |   |  |   |   |
| 687                 | ficate<br>p phys   | edical         |   | <b>L</b> d   |                                      |  |   |  |   |   |
| Box                 | leath certific<br>attending p  | N/u            | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf pre                                  |                                      | Testonio program                               | 201   |  | 23d. Date of del                                  | ivery   |
|                     | death  | Physician/Me   | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnant at time of  |                                      | _lEctopic pregnar<br>_l Other <i>(specify)</i> |   |  | Month   | Day Year  |
| <u>Р</u>            | at the<br>by th  | hys            | 9 ☐ Unknown   |  | -2550-73-                            | 7.77   | -10/9:12:21                                   | =  |   |   |
| Ś                   | w requires that the d<br>been signed by the<br>should be detached  | δ              | Part II. Other significant conditions   | contributing to death but not i                              | resulting in the u                   | inderlying cause (                             | given in Part I.                              | 23e. Did to                                  | bacco use contribute to<br>es 2 □ No 3 □ Pr       |   |
| 50                  | requi  | ted            |   |  |                                      |  |   |  |   |   |
| Records,            | e law<br>has b   | Completed      |   |  |                                      |  |   | 24a. Was a autops perfor                     | sy prior to comed2 death?                         | topsy findings available completion of cause of |
| a                   | sician: The<br>certificate harector, page  |                |   |  |                                      |  |   | 1□ Yes                                       |   | 2 □ No  |
| Vita                | sicial<br>certii<br>recto  | Be c           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No   | Hospital: 1 Minpatient 2                                     | ER/Outpatie                          | nt 2000  | )ther:  | th (Check only or                            |   | ~ .   |
| Ö                   | ding Phys<br>h.<br>After this<br>funeral dir   | ): To          | 27. Manner of Death   | 28a. Date of Injury  | 28b. Time o                          | II JUDON                                       | 4 LI Nursing H                                |  | ence 6 □Other (Sperow injury occurred             | orry)   |
| 0                   | ndlng<br>th.<br>r: Afte<br>e fune  | atior          | 1 Natural 5 Pending<br>2 Accident investigatio  | (Month, Day Year   | ) Injury                             |  | /ork?<br>□Yes 2□No                            |  |   |   |
| Division or         | Atte   | ifica          | 3 ☐ Suicide 6 ☐ Could not be determined   |  | t home, farm, st                     | reet, factory, offic                           | e   | 28f. Location (S. City or Town               | treet and Number or Run. State)                   | ıral Route Number,                              |
|                     | Ital on rs after ral Distriction   | Certification: |   |  |                                      |  |   |  |   |   |
|                     | Hosp<br>4 hou<br>Fune<br>tely fil  | ical           | (Check only 2 Medical Exa   | hysician: To the best of my l<br>miner: On the basis of exam | knowledge, dea<br>iination and/or ir | th occurred at the<br>ovestigation, in m       | time, date and place<br>y opinion, death occu | e, and due to the our<br>rred at the time, o | cause(s) and manner as<br>date and place, and due | stated.<br>to the cause(s)                      |
|                     | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical        | one)  29b. Signature and title of certifier   | and manner stated.   |                                      | 29c. Lice                                      | nse number                                    | 2  | 29d. Date signed (Mont                            | h, Day, Year)                                   |
| 1                   | F 3 F ŏ  | )              | · M.//  | MP   |                                      | 7/   | 4089  |  | 3/21/20   |   |
|                     | and  | ا              | 30. Name and address of person who  | 7-1-   | tem 23a) (Type,                      |  | 1001  |  | 2/01/00   | -0  |
|                     | 100  |                | Mark Sanchez, M   | .D. 2001 Me  | dical P                              | kwy An   | napolis, N                                    | ſD 21401                                     |   |   |
| ١                   | Sta  |                | 31. Date filed (Month, Day, Year)   | 32 Registrar's Si  | gnature                              | -  | , ,   |  |   |   |
|                     | Registi  | ar             | MAR 2 6 2   | 008 Jane   | J. L                                 | ASAGE !  |   |  |   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, рΜ Katalin Paschke 2008 6:45 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Director 578-50-4292 87 April 1, 1920 Hungary Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 4920 Sentinel Drive #404 20816 United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pal Pusztai ၉ Ilona Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie S. Lawless / P.O.A One Dudley Court, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 4-2-2008 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate ca se (Final **Physician** Advanced dementia of the Alzheimer's type disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9☐Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $4\square$  Nursing Home  $5\square$  Residence 6  $\square$ Other (Specify)  $\square$ Hospice 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After (Month, Day Year) Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check one) 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 101 29b. Signat Zen D0064615 3/25/2008 30. Name(and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski 1355 Piccard Drive #100, Rockville, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 27 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03-23-2008 9:50 PM HATTIE BELL POUGH 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FUTURECARE PINEVIEW Prince George's Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Min. Months 1<sup>Mont</sup>30<sup>ay</sup>1<sup>y</sup>934 73 Anderson, SC 214-28-9586 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 to Yes 2 □ No Washington D.C. 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 20019 N.E. U.S.A. 314 Eastern Avenue, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □ Yes Ž No Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Cashier 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James D. Byrd Eloise Edmunds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Enterprise Rd. Upper Marlboro,MD 20774 Brenda M. Butler/daughter 78 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Lincoln Mem.Cemetery 03-28-08 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Many Hudgman W01374 Cedar Hill FH 4111 PA Ave. St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or can line. Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 1 Tes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending (Month, Day Year) Injury investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date/signed (Month, Day, Year)

The law requires that the death certificate be executed ng physician and as the burial-tran P.O. Box 68760. attending use for signed by the at the detached for Division or Vital Records, should certificate has birector, page 2 s or Attending Physician:

Examiner Physician/Medical Be Completed by funeral director, Medical Certification: To After this s after death. inby

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show at 28a-f sh notified

items 23a or iner must be n

r than "natural", or iter the Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

<u>ک</u>

Completed

Be

ပ္

with the Maryland

death

within 24 hours a To the Hospital

State Registrar

filled

31. Date filed (Month, Day, Year) 2008 MAR 2 6

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

30. Name and address of per on who completed call e of



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

eath (Item 255

(pe, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

| Kevin Alan Paso  |                | otate of Maryland / Department of Healt  | h and Mental Hygiene  |
|--|----------------|--|---|
| Dhusisi  |                | 1- For State Registrar 1. Decedent's Name (First, Middle,Last)   | Reg. No.  |
| Physici<br>Medical Exami   |                | Kevin Alan Paschal   | 2. Date of Death Month Day Year March 31, 2008  3. Time of Death 0817 hrs   |
| 4  |                | TOTE 0   | own, or Location of Death 4c. County of Death nesville Charles  |
| Funeral  |                |  | er 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or  |
| Director   |                | 217-27-9283 1 X M 2 F 36 Yrs. Months Usual Residence of Decedent   | s Days Hours Min. 01/05/1972 ForeignWashington, Country) DC   |
| any  |                | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits   |
| and<br>show  | 5              | Maryland Charles Hughesville   | 1 Yes 2 No  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.   | Director       | 10e. Street and Number 10f. Zip 5977 Swanson Creek Lane 2  | Code 10g. Citizen of What Country? USA  |
| h with the sams 23a  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent In Type Married 2 Armed Forces? 11. Never Married 2 Armed Forces?  | nt of Hispanic Origin? (Specify Yes or No-<br>fy Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black,<br>White, etc. |
| er deat  | Fun            | 1   Never Married   2   Married   Armed Forces?   If Yes, special   Yes   2   No   |   |
| ural"  | ğ              | or Dates:  | X No specify: Specify: White  Occupation (Give kind of work done 16b. Kind of Business/Industry   |
| 72 hou<br>"nat   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  | king life. DO NOT use retired)  |
| 5-0036<br>led within 7<br>tygiene.<br>to ther than   | ğ              | 12 Detailer  | Detailing   |
| 5-0<br>Hygie<br>othe   |                | 17. Father's Name (First, Middle, Last)  | 18.Mother's Name (First, Middle, Maiden Surname)  |
| 121<br>d be fi<br>ental I<br>arked   | Be             | Lawrence Delano Paschal  | Alice Joyce Smith   |
| D 27<br>should<br>and Me<br>7 is ma  | ပ              |  | (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |
| and 2 calth cen 2 traum  |                | Lawrence D. Paschal/Father 5977 Swan 20a. Method of Disposition 20b. Place of Disposition (Nam   | son Creek Lane, Hughesville, MD 20637 ne of cemetery, Date 20c. Location - City or Town, State  |
| MOFe,<br>Pages I a<br>tent of He<br>int: If ite  |                | 1 X Burial 2 Cremation 3 Removal from State crematory or other place)  |   |
| it. Partiment timent y or o  | -              | 4 Donation 5 Other Specify: Charles Memor 21. Signature of Funeral Service Licensee 22. Name and   |   |
| Baltil<br>permit.<br>Departm<br>Importa  |                | 22. Name and Brigsf  | Address of Facility ield-Echols Funeral Home, P.A. Three Notch Rd., Charlotte Hall, MD 20622  |
| Physician  |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of   | of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval   |
| /Medical   |                | failure. List only one cause on each line.   | Between Onset and Death   |
| xaminer  |                | Immediate Cause (Final disease or condition resulting in death)  a. Cardlac armythma  Due to (or as a consequence of):   |   |
|  |                | Sequentially list conditions, b. Cardionesaly complicated by met   | hadone and diazopam intoxication  |
|  | in             | if any, leading to immediate Due to (or as a consequence of):  |   |
|  | Examiner       | (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):  |   |
| ),<br>be executed<br>aician and<br>urial - transit   | a<br>E         | d  |   |
| be ex<br>ician   | dical          | Unpended PI line a-b, 27,28a-f, perME,g879 5/23/08 TI  |   |
| 68760<br>certificate b<br>nding physise se as the bu   | Ž              | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death  | 23d. Date of delivery   |
| Cords, P.O. Box 68760 law requires that the death certificate I has been signed by the attending physical blood of the deached for use as the busined by deached for use as the business the business of the b | Physician/Me   | past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specific Specific | 3 Ectopic pregnancy Month Day Year  ify)  |
| at the   |                | Part II. Other significant conditions contributing to death but not resulting in the underlying  | cause given in Part I. 23e. Did tobacco use contribute to the cause of death?   |
| , P.O. res that the signed by be detacled  | d by           |  | 1 Yes 2 No 3 Probably 4 ✔ Unknown   |
| Division of Vital Records, tal or Attending Physician: The law require its after cleath all Director: After this certificate has been siled in by the funeral director, page 2 should b  | Completed      |  | 24a. Was an 24b. Were autopsy findings available  |
| eco<br>he law<br>te has  | ᇍ              |  | autopsy prior to completion of cause of death?  |
| II R   | Ö              | 25. Was case referred to medical   | 1 Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one)  |
| Vita<br>ysicia<br>his ce<br>direct   | ω,             | examiner?  | OA Other Nursing Home 5 Residence 6 Other Scene   |
| Of ng Ph   | 2              |  | 28c. Injury at Work? 28d. Describe how injury occurred  |
| ion<br>tendin  | 흹              | Pending Fnd 3/31/2008 Fnd 8.00 cm  | 1 Yes 2 X No unk  |
| ViSi<br>or Att<br>fter d<br>jirect<br>in by  | ij             | 2   Accident   Investigation   3   Suicide   6   Could not be   28e. Place of Injury - At home, farm, street, factory,   |   |
| pital Di   | Certification: | 4 Homicide A determined (Specify) found: residence   | or Town, State)<br>5977 Swanson Creek In. Hughesville, M  |
| Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b   | Medical (      | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the one)  2 Medical Examiner: On the basks of examination and/or investigation, in my and manyler stated.  | time, date and place, and due to the cause(s) and manner as stated.   |
| F 3 F 8  | Me             |  | License number 29d. Date signed (Month, Day, Year)  |
|  |                | 4/m  | O.C.M.E. April 1, 2008  |
|  | ŀ              | 30. Name and address of person who completed cause of death (Item 23a)   |   |
|  |                | David Fowler M.D. Chief Medical Examiner 111 Penn Street, Ba   | altimore, MD 21201  |
|  | ate            | 31. Date filed (Month, Day, Year) 32/Registrar's Signature   |   |

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**OCMF** 

SECRETARY GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 1s marked any Injury or other traumatic evonce. MOSES GOODRICH LUCY CUPID 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAELA RASCOE/DAUGHTER 1902 MICHAEL ROAD WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 03/29/08 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD 21. Signature of funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the diseale or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) CORDNARY ARTERY /Medical Examiner HYPER CHOLECTROLENIA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine UNCONTROLLED HYPERTENSION attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONGENITAL HEART DUENSE, OBESITY-HORBID, Completed DISORDER, OBSTRUCTIVE SLEEP APNOED SELVULE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No CHRONIC OBTUCTIVE PULLONICY autopsy performe DISEASE CHRONIC OBSTUCTIVE PULLONARY performed? CHRONIC KIDNEY or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/24/0 8. D 40395 N.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARA RAMACHANDRAN 1221 MERCENTILE LANE UPPER MARLBORO, MD 20774 31. Date filed (Month, Day, Year) State MAR 2 8 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Director 577**-**56**-**5935 66 11/30/1941 WASHINGTON, DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f shovaminer must be notified at 1 Yes 2 No Director CHARLES WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 20601 1902 MICHAEL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ould be filed within 72 hours after on Mental Hygiene. Arked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ Specify: BLACK 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

WALDORF

4b. City, Town, or Location of Death

2. Date of Death

03/21/2008

4c. County of Death

CHARLES

4:26 A M

1. Decedent's Name (First, Middle, Last)

VECELIA H. RASCOE

1902 MICHAEL ROAD

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

|                     |   |                      | 1- For State of Maryland / De Registrar   | partment of Health and Nertificate of Death   |  | ene 0 0 8                             | 11784  |
|---------------------|---|----------------------|---|---|--|---------------------------------------|--|
|                     | Physic  |                      | Decedent's Name (First, Middle, Last)     Rosemary Guyther Roberts  |   | 2. Date of Death<br>Month<br>March 24, | Day Year<br>2008                      | 3. Time of Death<br>12:50 p M  |
|                     | /Medi<br>Examir   |                      | 4a. Facility Name (If not institution, give street and number) Sacred Heart Home  | 4b. City, Town, or Location of Death Hyattsville  |  | 4c. County of Dea                     |  |
|                     | Funeral<br>Director   |                      | 5. Social Security Number  578-03-8157  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthda  | Months Days Hours Min.  | 8. Date of Birth (Month, Day, Y        | (ear) C                               | thplace (State or Foreign<br>ountry)<br>Maryland                       |
|                     | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28e-f show eumatic event, if a Modical Examiner must be notified at                     | Director             | 10a. State 10b. County 10c. City, Town or   | Location at tsvi.lle  | 100                                    | g. Citizen of What C                  | 10d. Inside City Limits 1 ☐ Yes 2X No ountry?                          |
| 0                   | be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural", or flems 23a or 28e-f show other then "natural", or flems 23a or 28e-f show event, it a Modical Examination at the modified at | Funeral              | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No  | 20782  3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto                           | ecify Yes or No-<br>Rican, etc.)       | USA<br>14. Race - Am<br>Black, Whi    | te, etc.   |
| Maryland 21215-0036 | hin 72 hours a<br>b.<br>no "natural", o<br>Medical Exac   | Completed by         | (Specify only highest grade completed) (Gi  | 1 ☐ Yes 2☑ No Specify:  cedent's Usual Occupation we kind of work done during most of work  DO NOT use retired) | ing 16                                 | Specify: Who                          |  |
| land 21             | ld be filed witl<br>ental Hygiene<br>ked other the<br>ic event, the   | To Be Com            |   |   | e (First, Middle, Ma<br>Rosa Beal      |                                       | e Sector   |
| e, Mary             | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic es <u>once</u> .   | _                    | Jean Carleton Malinowski/Niece  | uling Address (Street and Number or Run<br>44180 Mossy Brook Squa   | re, Ashburn                            | , VA 20147                            |  |
| Baitimore,          | t. Pages I<br>rtment of H<br>rtent: If ite  |                      | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Temperature Comments of the Comments of t | oln Cemetery  | March 28,<br>2008                      | c. Location - City or<br>Brentwood,   |  |
| מ                   | Depa<br>Impo<br>any it  |                      |   | 22 Name and Addicastifacility Fune<br>500 University Blvd., W   | ., Silver S                            | pring, MD 2                           | 20901<br>Approximate   |
| g/on,               | death certificate be executed  Wedical  Exam  de attending physician and defor use as the burial-transit  | dical Examiner       | shock, or healt failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  ### Last only one cause on each line.  #### Multi-Organ Failure  Due to (or as a consequence of):  ### Due to (or as a consequence of):  #### Atherosclerosis  Due to (or as a consequence of):  ###################################   |   |  |                                       | Interval Between Onset and Death more than 1 yr.  more than 6 mc years |
| O. Box 6            | ath certi<br>attending<br>for use a   | Physician/Me         |   | B⊟Ectopic pregnancy<br>□ Other (specify)  |  | 23d. Date of de<br>Month              | livery<br>Day Year   |
| cords, r            | w requires that the de<br>been signed by the<br>should be detached  | by                   | Part II. Other significant conditions contributing to death but not resulting in the Osteoporosis, Ovarian Cancer   | underlying cause given in Part I.   |  |                                       | o the cause of death?<br>robably 4 DUnknown                            |
| L                   | The lar<br>ate has<br>page 2  | e Completed          | 25. Was case referred to medical  |   | 24a. Was an autopsy performe           | d? prior to death?                    | utopsy findings available completion of cause of 2 No                  |
| 5                   | ding Phys<br>n.<br>After this<br>funeral di   | Certification; To Be | examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Could get be   | of 28c. Injury at Work?  M 1 Yes 2 No   | 28d. Describe how                      | injury occurred                       |  |
| 2                   | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune  |                      | 4 Homicide determined 200 Frace of injury At nome, farm, so building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea   | ath occurred at the time, date and place.   | City or Town, S                        | se(s) and manner as                   | stated   |
|                     |   | Medical              | (Check only one)  2 Medicel Exeminer: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier  | investigation, in my opinion, death occurr  | ed at the time, date                   | and place, and due  Date signed (Mont | to the cause(s)  |
| 1                   | 0   |                      | 30. Name and address of person who completed cause of death (Item 23a) (Type Raman Tull, MD 10810 Darmestown Road, #20  | e, Print)   |  | . 7 7 0                               |  |
|                     | Sta<br>Registr  |                      | 31. Date filed (Month, Day, Year)  MAR 2 7 2008  32 Registrar's Signature   |   |  |                                       |  |

**ORIGINAL** 

# Reddick, Arthur

|  |  |  | State of Maryland / Department of Health and M   | lental Hygie                            | ne   |  |  |
|--|--|--|--|---|--|--|--|
|  |  | 1 - State Registrar Certificate of Death Reg. No. 2000 |  |   |  |  |  |
|  | Physicia   |  | 1. Decedent's Name (First, Middle, Last)   | Date of Death     Month                 | Day Year                                       |  |  |
|  | /Medic   |  | Arthur Zacharias Reddick   | March &                                 | 21, 2008 6:55AM                                |  |  |
| J  | Examin   | er   | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   |   | 4c. County of Death                            |  |  |
| 1  | The second second second   |  | Doctor's Community Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.  | 8. Date of Birth                        | Prince George's                                |  |  |
|  | Funeral Director   |  | 429-84-9738 Days Hours Min.  | (Month, Day, Ye                         |  |  |  |
| Н  | and section with the second  |  | Usual Residence of Decedent  | May 15,                                 | 1944   Arkansas                                |  |  |
|  | how at   | ,  | 10a. State 10b. County 10c. City, Town or Location   |   | 10d. Inside City Limits                        |  |  |
|  | e Ma<br>Sa-f s   | cto  | Maryland Prince George's Greenbelt   |   | 1 ☐ Yes 2 ☐ No                                 |  |  |
|  | or 28  | Dire   | 10e. Street and Number 10f. Zip Code   | 10g.                                    | Citizen of What Country?                       |  |  |
|  | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at   | Funeral Director                                       | 7904 Spring Manor Drive 20770  |   | United States 14. Race - American Indian,      |  |  |
| •  | item   | un:  | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No  1 □ Never Married 2 □ No  | Rican, etc.)                            | Black, White, etc.                             |  |  |
| 36   | irs aft  | by F   | 1  Never Married 2 Married 1  Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:   |   | Specify: African American                      |  |  |
| 21215-0036                                   | 2 hou  | ted  | 15. Decedent's Education 16a. Decedent's Usual Occupation  | 165                                     | p. Kind of Business/Industry                   |  |  |
| 215  | hin 7;<br>s.<br>an "n<br>Medi  | Completed  | (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)   | ing                                     |  |  |  |
| 21;  | d with   | ωo   | l year Dispatcher  |   | Private  |  |  |
| nd   | be file<br>tal Hy<br>d oth   | Be (   |  | e (First, Middle, Mai                   | den Surname)                                   |  |  |
| yla  | Meni<br>Meni<br>arked  | P  |  | Sloane                                  |  |  |  |
| Maryland                                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |  | 19a. Informant's Name/Relationship (Type. Print)  Marie L. Reddick - Spouse  19b. Mailing Address (Street and Number or Run.  7904 Spring Manor Drive  |   |  |  |  |
|  | 1 and<br>Healtl<br>sm 27<br>ther t   |  | 1  |   | c. Location - City or Town, State              |  |  |
| Baltimore,                                   | ages<br>nt of l  |  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  |   | •  |  |  |
| Ħ  | iit. Partme  |  | 4 □ Donation 5 □ Other (Specify)   |   |  |  |  |
| Ba   | Depart Impo  |  | ANU A WALL 4001 Benning Road,  |   |  |  |  |
|  | -  |  | 23a, Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  |   |  |  |  |
| 1  | Physician  |  | Construction Construction (Construction Construction Cons |   | Onset and Death                                |  |  |
|  | /Medical   |  | disease or condition resulting in death)  a. Um - amall cell lung Common resulting in death)  Due to (or as a consequence of):   | مف                                      |  |  |  |
|  | Examiner   |  | 4.   |   |  |  |  |
|  |  | ner  | Sequentially list conditions, if any leading to firmediate cause. Enter Underlying Cause (Disease or injury that initiated events  |   |  |  |  |
|  | ecutec<br>nd<br>transi   | Examiner   |  |   |  |  |  |
| 90,  | e exe<br>ian a<br>urial∹   |  | resulting in death) Last  Due to (or as a consequence of):   |   |  |  |  |
| 8760,  | cate be executed<br>physician and<br>the burial-transit  | Completed by Physician/Medical                         | d. Uhemia  |   |  |  |  |
| 9 ×  | death certific<br>e attending p<br>d for use as  | /Me  | IF FEMALE: 23c. If yes, outcome pf pregnancy   |   |  |  |  |
| Вох  | atten<br>for us  | lan  | in the past 12 months?   |   | 23d. Date of delivery  Month Day Year          |  |  |
| P.O.   | 0 0 0  | ysic   | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown   |   |  |  |  |
|  | requires that the<br>een signed by the<br>ould be detache  | y Ph   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobac                          | co use contribute to the cause of death?       |  |  |
| Records,                                     | quires<br>n sigr<br>ald be   | q p  | Diabetes mellibis  | 1 ₽ Yes                                 | 2 No 3 Probably 4 Unknown                      |  |  |
| ၀  | s bee  | olete  | Le rene diande   | 24a. Was an                             | 24b. Were autopsy findings available           |  |  |
| æ  | The lav  | mo   |  | autopsy<br>performed<br>1 Yes 2 ☑       |  |  |  |
| Vital  | ician: Th<br>certificate<br>ector, pag   | Be C   | 25. Was case referred to medical 26. Place of Death  | (Check only one)                        | 110 15163 2510                                 |  |  |
| r <  | Physician:<br>r this certific<br>ral director,   | 일  | examiner?  1   Yes 2   No  | me 5□Residenc                           | e 6 □Other (Specify)                           |  |  |
| 0 U  | ng Pl  | ï.   |  | 28d. Describe how i                     |  |  |  |
| Division or                                  | Attending<br>r death.<br>ector: After<br>by the funer  | Certification:   | 2 Accident Investigation M 1 Yes 2 No  |   |  |  |  |
| <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u> | after de la Direct   | Ħ  | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (Stree<br>City or Town, S | at and Number or Rural Route Number,<br>State) |  |  |
|  | pital<br>urs a<br>eral E   |  | 29a. Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place,   | and due to the                          | pa(a) and manner as atotad                     |  |  |
|  | Hospital 24 hours a Funeral etely filled   | Medical  | 29a. Certifier  (Check only one)  1 ─ ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  |   |  |  |  |
|  | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,   | Mec  | 29b. Signature and title of certifier 29c. License number  | 29d.                                    | Date signed (Month, Day, Year)                 |  |  |
|  | F>Fo   |  | D0062116   | 3                                       | 5/21/08  |  |  |
| 06   | (5)  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |   | 110  |  |  |
| Y  |  |  | MEKLIT WORKNEH, 7705 Belle Point Drive,  | Greenb                                  | 0ff0s CM +15                                   |  |  |
|  | Sta  |  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |   |  |  |  |
|  | Registr  | ar   | MAR 2 6 2008 Reserve & Aprile  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6188 0 x0 11/1/ Rd # 70/ Uchechi 7. Offgiq 5004, mp 0 x0n 1/1/, mp 70745 32. Registrar's Signate 31. Date filed (Month, Day, Year) MAR 2 8 2008

29b. Signature and title of certifier

29c. License number

D037066

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Edmund Keith Stevenson 25, 2008  $0807 A^{M}$ March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Olney Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/12/1954 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1√2 M 2 □ F 577-72-8007 53 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show MD 1 Yes 2 No Director Montgomery Wheaton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code be o 11430 Amherst Avenue, apt#8 20902 U.S.A. r than "natural", or items 23a the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black \$ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Edmund Stevenson, Jr. Constance T. Rivers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Damien K. Stevenson- Son 10505 Althea Court; Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crem. 3/31/2008 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funetal Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part Tenter the disease, or c m dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List o ly the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ept: cemo **Physician** /Medical Due to (or as a consequence of): Examiner Arrhy Tlenus ardonas Sequentially list conditions, Due to for as a consequence off: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last R heuned field that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after thin 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059981 -3hollla MArch 25, 200 &

31. Date filed (Month, Day, Year) MAR 2 8 2008

Abolella, mD 6005 LANDOVER RD Smite 3, chevery, mo 2005 Mukemil 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registral AMEND#29dperMD3-27-08, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 17, 2008 **Physician** Smith Robert 1420 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton

| f Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov. | 11, 1 Prince Georges Future Care Nursing 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F 1930 Yrs Anderson, S.C. 578-36-2879 77 Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 K Yes 2 □ No Washington Director District of Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or other traumatic event, the Medical Examiner must be 20002 107 Franklin Street, N. E. U. S. A. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after oal Hygiene.
I dyber than "natural", or iter 1 XYes 2 No If Yes, Give Year or Dates:1950 -1952 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify **Black** ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Retired Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of John S. Kirksey Odessa Mary I. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Franklin St, N. E. Wash. D. C. Apt. D22 Sharon K. Smith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) DateUkn. 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW, Washington, DC 20011 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulminary dylas Immediate Cause (Final b59 ructive **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 5 MOKE ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ins certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown 1055 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 7 - 2008 29b. Signature and title of certifier 1) 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D.7801 Old Branch Ave; Clinton, MD 20735 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAR 27 2008

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** рМ March 24 2008 Jefferson 8:00 Robert Stephens /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Manor Care-Silver Spring Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Days 1**X** M 2 □ F Yrs. Director 218-20-0104 81 July 21, 1926 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Mon topomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20910 LISA 9808 Crosby Place Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐ Yes 2√∑ No Specify þ 3 Widowed 4 ☐ Divorced Specify: White WWTT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than 's traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning 10 Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be ဂ Charles Campbell Stephens Flossie Estelle Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Robert L Stephens/Son 11566 Windsor Road, Ijamsville, MD 21754 aftimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Baptist Church 20a. Method of Disposition 20c. Location - City or Town, State March 1 Burial 2 □ Cremation 3 🖾 Removal from State King George, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? this certificate of Vital 1 □ Ýes 2XXN0 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State

Registrar

2011

Darryl Hill, MD

31. Date filed (Month, Day, Year)

MAR 2 7 2008

30. Name and address of person Ino completed cause of death (Item 23a) (Type, Print)



13635 Baltimore Avenue, Laurel, MD 20707



D53235

March 26, 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 IDA MAE SKLAREVSKI March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 □ M 2 🕁 F 217-28-5691 79 10, 1928 Maryland Sept. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show at Yes 2 No or items 23a or 28a-f shaminer must be notified Director Maryland Frederick Sabillasville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 17043 Sabillasville Road 21780 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nrt: If item 27 is marked other than "natural", or items 23. Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White 3 Widowed 4 □ Divorced or than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Şecondary (0-12) College (1-4or 5+) Homemaker Own Home Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther Hahn Ida Jacobs ၟႍ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Noel E. Sklarevski, Jr./Son 17043 Sabillasville Road, Sabillasville, MD 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 3/31/08 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, 21. Signatur 615 EAST MAIN ST., THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or shock, or heart failure. List death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 3 dans XICL resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months 5 Other (specify) signed by the a □Yes 2♥No 9 Unknown outing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions cont 3 Probably 4 ☐ Unknown 2□ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ N 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Impatient မ this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Within 24 hours are.

To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) and address of pers impleted cause of death (Item 23a) (Type, Print) 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

| Zachary | Evan   | Sowers |
|---------|--------|--------|
|         | - 4011 | 000000 |

| chary Evan S   |                      | 1- For State   | ate of Maryla   | and / Depa                         | artment of<br>rtificate of                 | f Healt                  |                         | Menta                    | l Hy           | giene                          | Dog No              |                        | 0               | 8 1179   |
|--|----------------------|--|---|------------------------------------|--|--------------------------|-------------------------|--------------------------|----------------|--------------------------------|---------------------|------------------------|-----------------|--|
| Physici<br>edical Exami  | an/                  | Registrar  1. Decedent's Name (First, Middle Zachary E.  |   |                                    | timodic or                                 |                          |                         |                          |                | Date of Do<br>Month<br>March 2 | Day                 | Year                   |                 | 3. Time of Death<br>2200 hrs                       |
| ×.6  |                      | 4a. Facility Name (if not institution<br>Johns Hopkins Bayviet   |   |                                    |  | 4b. City, T<br>Baltin    |                         | ocation of D             |                | Maioriz                        |                     | c. County of           | Death           |  |
| Funeral<br>Director  |                      |  | 6. Sex  | 7. Age (In yrs. I                  |  | Month                    | s Days                  | If Under 2<br>Hours      | 24Hrs.<br>Min. |                                |                     | 1979                   | 9. Birth<br>Cou | nplace (State or Foreign ntry) Ohio                |
| i<br>ow any  |                      | Usual Residence of Decedent 10a. State 10b. County   |   | 10c. City                          | Town or Locati                             |                          |                         |                          |                |                                |                     | ·                      | T               | 10d. Inside City Limits 1 Xyes 2 No                |
| he Maryland<br>1 or 28a-f sh<br>ified at one   | Director             | Maryland 10e. Street and Number 305 South Robin  | son Stre  | et                                 | ватт                                       | 10f. Zip                 |                         | 4                        |                |                                |                     | ted St                 |                 | ry?  |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | Completed by Funeral | 11. Mantal Status 1 Never Married 2 X Ma 3 Widowed 4 Divo  |   | 2 X No                             | If Y                                       | es, specif               |                         | Mexican, P               |                | cify Yes or lican, etc.)       | No-                 | White,                 |                 | an Indian, Black,                                  |
| 6<br>172 hours aft<br>an "natural"<br>ical Examine   | eleted by            | 15. Decedent's Education (Spec<br>Elementary/Secondary (0-12)  | fy only highest gra                                       | de completed)                      | 16a. Deceden<br>during me                  | it's Usual<br>ost of wor | Occupation king life. D | n (Give kin<br>OO NOT us |                |                                |                     | . Kind of Bus          | ness/In         | dustry   |
| 215-003<br>be filed within<br>ttal Hygiene.<br>ked other th  | Be Comp              | 17. Father's Name (First, Middle, Gary Sowers  | +4<br>Last)   |                                    | Finar                                      | nciai                    |                         |                          | ,              |                                |                     | n Surname)             | ge u            | niversity  |
| MD 21<br>12 should I<br>th and Mer<br>127 is man   | J.                   | 19a. Informant's Name/Relationsh<br>Anna Cheng / W   |   |                                    | 305 8                                      | South                    | Rob:                    | inson                    |                |                                |                     | City or Town<br>timore |                 | Zip Code)<br>D 21224                               |
| Imore, Pages l and nent of Heal ant: If iten   |                      | 20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spo   | ecify:  | om State                           | Place of Disposicrematory or other inglawr | ner place)               |                         |                          |                | Date<br>9/2008                 |                     | . Location - 0         |                 | own, State   |
|  |                      | 21 Signature of Funeral Service I  | icensee<br>Tauffe   | 7                                  |  | 1621                     |                         | ssumt                    | own            | Pike:                          | , Fr                |                        | k,              | e<br>MD 21702<br>Approximate Interval              |
| Physician Medical Examiner   |                      | failure. List only one cause of<br>Immediate Cause (Final disease or condition resulting in death)   | on each line.<br>a. Blunt Force                           |                                    |  | ne mode d                | or dying, st            | ich as card              | alac or r      | espiratory                     | arrest, si          | nock, or near          | ı               | Between Onset and<br>Death                         |
| 1  | er                   | Sequentially list conditions, if any, leading to immediate   | b   | consequence o                      |  |                          |                         |                          |                |                                |                     |                        |                 |  |
| nted<br>d<br>ansit   | Examiner             | cause. Enter Underlying Cause<br>(Disease or injury that Initiated<br>events resulting in death) Last  | Due to (or as a   | consequence o                      | f):  | -                        |                         | · · · · · ·              |                |                                |                     |                        |                 |  |
| 50,<br>te be executed<br>ysician and<br>burjal - transit   | ledical              | UNPENDED IF FEMALE:  | AMENDED   |                                    |  |                          |                         |                          |                |                                | 10                  | 2d Date of d           | بمماناه         |  |
| Box 6876<br>death certificate<br>the attending phy<br>of for use as the b  | Physician/Me         | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr   | 1 Live b  | ant at time of de                  | 2 Fet                                      | tal death<br>her (Spec   | 3                       | Ectopic pi               | regnand        | су                             |                     | 3d. Date of d<br>Month | Da              | ay Year  |
| P.O. I es that the iigned by the be detache  | by                   | Part II. Other significant condition   | ons contributing to                                       | death but not n                    | esulting in the u                          | ınderlying               | cause giv               | en in Part I             | I.             |                                |                     |                        |                 | ne cause of death?                                 |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the purial - transition o | Completed            |  |   |                                    |  |                          |                         |                          |                | 1 Yes                          | is an opsy formed?  | pri<br>de              |                 | opsy findings available impletion of cause of 2 No |
| Vital ysician: this certi  | o Be                 | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No   | Hospital: 1   | npatient 2                         | ER/Outpatient                              |                          |                         | f Death (Ci<br>ther:4 N  |                | Home 5                         | Resid               | ience 6                | Other:          |  |
| ion of \ nending Physeuth. tor: After the funeral.   | ation: T             | 27. Manner of Death  1 Natural 5 Pendi   | 28a. Date<br>(Month<br>Jun 2, 2                           | of Injury<br>Day,Year)<br>007      | 28b. Time of Ir<br>0013 hrs                | njury 2                  | 28c. Injury             | at Work?<br>s 2 ✔ N      | ls.            | 8d. Describ<br>ubject be       |                     | njury occurre          | 1               |  |
| Division To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the  | Certification:       | 3 Suicide 6 Could 4 V Homicide   | not be nined (Specify)                                    | e of Injury - At he<br>Local Stree | et   |                          |                         |                          | 30             | or Town<br>00 Block o          | , State)<br>f South | Robinson               | Street          | al Route Number, City Baltimore, MD                |
| To the Hovithin 24   | edical               | (Check only one) 1 Certifying Physical Example 2 Certifying Physical Example 2 Certifying Physic | vsician: To the best<br>siner:On the basis<br>and manuers | of examination a                   |  |                          |                         |                          |                |                                |                     |                        |                 |  |
| ~10°   | Me                   | 29b. Signature and title of certifier  | Mh  | _                                  |  | 290                      | O.C.M                   |                          |                |                                |                     | Date signed arch 27, 2 |                 | th, Day, Year)                                     |
|  |                      | 30. Name and address of person of David Fowler M.D.  | who completed caus<br>hief Medical E                      | ,                                  | <sup>23a)</sup><br>11 Penn St              | reet, Ba                 | altimore                | , MD 21                  | 201            |                                |                     |                        |                 |  |
| St<br>Regis  | ate<br>trar          | 31. Date filed (Month, Day, Year)  | 2008 32.  | gistrar's Signatu                  | the April                                  | The same                 | -                       |                          |                |                                |                     |                        |                 |  |

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

|  |  |                     | 1 - State<br>Registrar   | e of Marylan   |                                  | artment of F   |                                     | nd Mental Hy                                 | giene<br>Reg. No. 2008                        | 11792  |
|--|--|---------------------|--|--|----------------------------------|--|-------------------------------------|--|---|--|
|  | Physici  | an                  | 1. Decedent's Name (First, Middle, Last)  Charles  Lev   | in S   | nurr                             |  |                                     | 2. Date of De.<br>Month<br>March             | 25, 2008 ear                                  | 3. Time of Death 6:42 A. M                         |
| ,                                      | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give street an St. Catherines Nursin  | d number)  |                                  | 4b. City, Town, o  |                                     |  | 4c. County of Deatt                           | h  |
|  | Funeral<br>Director  |                     | 5. Social Security Number 220–18–3208  | 7. Age (In yrs. 82   | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days   | If Under 24<br>Hours                | Min. (Month, Da                              | th<br>y, Year) 9. Birth<br>Co<br>3,1926 Mary  | nplace (State or Foreign<br>untry)<br>1and         |
|  | Maryland   | tor                 | Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick  |  | y, Town or Lo                    |  |                                     |  |   | 10d. Inside City Limits 1XXYes 2 ☐ No              |
|  | ith the  | Olrec               | 10e. Street and Number   |  |                                  | 10f. Zip Code  |                                     |  | 10g. Citizen of What Co                       | untry?   |
|  | e 23a  | ral                 | 110 Catoctin Avenue  |  |                                  | 2178   |                                     |  | USA   |  |
| 2                                      | permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.  Important: if tien 27 is marked other then "naturel" or iteme 23a or 28a-f show any injury or other traumatic event, it a Modical Exam. ar must be notified at once.                                 | by Funeral Director | 1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | Decedent Ever in U<br>od Forces?<br>Yes 2 ☐ No<br>s, Give WW I<br>or Dates:    |                                  | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 21 No  | Ispanic Originan, Mexican, Specify: | n? (Specify Yes or No<br>Puerto Rican, etc.) | 14. Race - Ame<br>Black, White<br>Specify: Wh | e, etc.  |
| 0-0-1                                  | thin 72 hore. e. Medical I   | Completed           | 15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12) Colle   | sted)<br>ge (1-4or 5+)   | 16a. Deced<br>(Give<br>life. L   | tent's Usual Occup<br>kind of work done<br>OO NOT use retired  | ation<br>during most o              | of working                                   | 16b. Kind of Business/                        | industry   |
| 7                                      | iled wi<br>tygien<br>her th<br>nt, Ite   |                     | 11. Father's Name (First, Middle, Last)  |  | Pres                             | s Superv   |                                     | - Non- (Fine Asiddle                         | Business F                                    | orms   |
|  | id be f<br>ental h<br>ked of   | To Be               | Charles Willia   | ım   | Snurr                            |  | Lue                                 | s Name <i>(First, Middl</i> e,<br>11a        | Stitelev                                      |  |
| a                                      | and M<br>mar   | -                   | 19a. Informant's Name/Relationship (Type, Print  |  | -                                | g Address (Street  |                                     |  | er, City or Town, State, 2                    | Zip Code)  |
| <u> </u>                               | end 2<br>lealth<br>m 27 i  |                     | Janet Snurr/Wife   | lac. s   |                                  | Catoctin   | Ave.                                | Thurmont,                                    |   |  |
|  | Pages 1<br>tment of H<br>tant: if ite<br>ijury or ot   |                     | 20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)  | from State   | emetery, crem<br>een Hi          | sition (Name of natory or other place L1 Cemete  | ry 3/                               | Date / 29 / 2008                             | 20c. Location - City or Waynesboro            | , PA   |
| 2                                      | permii<br>Depar<br>impor<br>any ir   |                     | 21. Signature of Funeral Service Licensee  |  |                                  |  |                                     |  | Funeral Home                                  |  |
|  | Physician  |                     | 23a. P. rt. The diseas and implications such or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) | hat caused the deat  |                                  |  |                                     |  | ont, MD 2178                                  | Approximate<br>Interval Between<br>Onset and Death |
| ı                                      | /Medical<br>Examiner   | Iner                | Sequentially list conditions.  | e to (or as a conseq<br>e to (or as a conseq                                   |                                  |  |                                     |  |   |  |
| ,0070                                  | cate be executed<br>ohysicien and<br>the burial-transit  | dical Examiner      | that inflated events   | e to (or as a conseq   | uence of):                       |  |                                     |  | 0   |  |
| O. DOY O                               | To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours attar death.  To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, pege 2 should be datached for use as the burial-transit | Physician/Medical   | in the past 12 months?   | s, outcome of pregna<br>live birth 2 Feta<br>Pregnant at time of d<br>Jinknown | Ideath 3                         | Ectopic pregnancy Other (specify)  | /                                   |  | 23d. Date of del<br>Month                     | ivery<br>Day Year                                  |
| . (cp.                                 | quires thet<br>en signed by<br>tuld be data  | 6                   | Part II. Other significant conditions contributing   | to death but not res   | ulting in the u                  | nderlying cause giv  | en in Part I.                       | •  | obacco use contribute to<br>Yes 2 No 3 Pr     | the cause of death?                                |
| יייייייייייייייייייייייייייייייייייייי | : The law re<br>cete hes be<br>, pege 2 shd  | Completed           | Insulin Depen  | dent   | Dist                             | oetas  | Melli                               | 24a. Was<br>autor<br>perfo                   |   | topsy findings available completion of cause of    |
| <b>X</b>                               | sician<br>certifi<br>irector   | o Be                | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital:   | 1 Classian - 0 C   | FR/0:                            | . all post Oth   |                                     | of Death (Check only of                      |   |  |
| 5                                      | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2  | atlon: To           |  | 1 ☐ Inpatient 2 ☐<br>Date of Injury<br>(Month, Day Year)                       | 28b. Time of<br>Injury           | 28c. Injur   | 4 LANUIS                            | 28d. Describe                                | dence 6 Other (Spe<br>how injury occurred     | cify)  |
|  | tai or Atters aftar des  | Certification:      | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.   | Place of Injury - At ho<br>building, etc. (Specif                              | ome, farm, str                   | eet, factory, office   |                                     | 28f. Location (.<br>City or To               | Street and Number or Ru<br>wn. State)         | ural Route Number,                                 |
|  | the Hospl<br>nin 24 hou<br>the Funer<br>npletely fill  | ledical             | /-/-/-   | o the best of my know<br>the basis of examina<br>manner stated.                | wledge, death<br>tion and/or inv | vestigation, in my o   | pinion, death                       | occurred at the time,                        | date and place, and due                       | to the cause(s)                                    |
|  | J WE CO  | ×                   | 29b. Signature and title of certifier  | -Cou   | roll                             | 29c. Licens  |                                     | 05   | MARCH 25,                                     |  |
| 1                                      | H  |                     | 30. Name and address of person who completed Alan Carroll 310 S.   | Seton Ave  |                                  |  | or MD                               | 21727  |   |  |
|  | Sta<br>Registr   |                     | 31. Date filed (Month, Day, MAR 2 7 20   | 32 Registra s Signa  | iture _                          | A STATE OF THE PARTY OF THE PAR |                                     | 41141  |   | · · · · · · · · · · · · · · · · · · ·              |

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|             |  |                   | For State  | State of Marylan  |                              |   |   |                                   | 000                              | 0 11700                               |
|-------------|--|-------------------|--|---|------------------------------|---|---|-----------------------------------|----------------------------------|---------------------------------------|
|             |  |                   | Registrar  1. Decedent's Name (First, Middle, Last,                              | )   | Cei                          | rtificate of  | Deam  | 2. Date of Deat                   | eg. No.                          | 3. Time of Death                      |
|             | Physicia   |                   | Richard Hurd Spran   |   |                              |   |   | Month                             |                                  | ar                                    |
|             | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, give                                      |   |                              | 4b. City, Town, o   | r Location of Death                         |                                   | 4c. County of [                  |                                       |
|             | LAdiiiii   | CI                | 11109 Rosewood Dr.   | •   |                              | Hagersto  | own   |                                   | Washingt                         | on County                             |
|             | Funeral  |                   | 5. Social Security Number 6. Sec   |   |                              | If Under 1 Year<br>Months Days                                | If Under 24 Hrs.<br>Hours Min,              | 8. Date of Birth<br>(Month, Day,  | 9.                               | Birthplace (State or Foreign Country) |
|             | Director   |                   | 215-26-2144  | XM 2□ F 74  | Yrs.                         | World Buys  | Tiours Iviiri                               |                                   |                                  | aryland                               |
|             | and  |                   | Usual Residence of Decedent  10a. State 10b. County                              | 10c. Cit  | y, Town or Lo                | cation  |   |                                   |                                  | 10d. Inside City Limits               |
|             | Maryl<br>f sho   | ō                 | Maryland Washingto   | n County Hag  | erstow                       | n   |   |                                   |                                  | 1 □ Yes 2 X No                        |
|             | the 28a  | Directo           | 10e. Street and Number   |   |                              | 10f. Zip Code   |   | 1                                 | 0g. Citizen of Wha               | t Country?                            |
|             | 3a o   |                   | 11109 Rosewood Dri   | ve  |                              | 21740   |   |                                   | U.S.A.                           |                                       |
|             | deat   | Funeral           | 11. Marital Status   | 12. Was Decedent Ever in U.                                     | S. 13. \                     |   | lispanic Origin? (Sp<br>an, Mexican, Puerto |                                   | 14. Race                         | American Indian,<br>Vhite, etc.       |
| 9           | or ite   |                   | 1 ☐ Never Married 2 【X Married   | Armed Forces? 1 □XYes 2 □ No If Yes, Give 1953—                 |                              | 1 □Yes 2 ဩ No   | Specify:                                    | Thoan, etc.,                      |                                  | White                                 |
| 21215-0036  | filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene with than "natural", or items 23a or 28a-f show ent, the Medical Evander or ust be notified at  | d by              | 3 ☐ Widowed 4 ☐ Divorced   | Year or Dates:  |                              | dent's Havel Occur  | otion                                       |                                   | 16b. Kind of Busin               |                                       |
| 5           | in 72  | olete             | 15. Decedent's Edu<br>(Specify only highest grad                                 | e completed)  | (Give                        | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of work<br>d)                   | king                              | TOD. KING OF BUSIN               | ess/maustry                           |
| 7           | r than   | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                              |   | house Op                                    |                                   | Truck Ma                         | nufacturer                            |
| ğ           | othe<br>vent,  | Be C              | 17. Father's Name (First, Middle, Last)  |   | ,                            |   | 18. Mother's Nam                            | e (First, Middle, I               | Maiden Surname)                  |                                       |
| Maryland    | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By its marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventure roust to not fine a standard once.   | To E              | Jacob Luther Spran   | kle   |                              |   | Bessie 1                                    | May Hurd                          | Sprankle                         | 9                                     |
| lar         | 2 sho  |                   | 19a. Informant's Name/Relationship (T)   |   | 1                            |   |   |                                   | r, City or Town, Sta             |                                       |
| e)          | l and<br>Fealth  |                   | Doris Jane Sprank1 20a. Method of Disposition                                    |   |                              |   |   |                                   | , MD 2174<br>20c. Location - Cit |                                       |
| altimore,   | nt of nt of ror or or or or or or or or or or or or  |                   | 1 Burial 2 □ Cremation 3 □ F   | removal from State  |                              | sition (Name of<br>natory or other place                      | •   |                                   |                                  |                                       |
| ≣           | artme  |                   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens        | ,ccu  | ar Lawi                      | n Mem. Pa   | rk 4-1-2                                    | 2008   1                          | Hagerstov<br>Fiory Fu            | vn, Maryland<br>Ineral Home           |
| Ba          | Dep Jany   |                   | Kaithin 30   | Maroni  | 13                           | 331 Easte   | ern Blvd.                                   | North H                           | agerstown                        | n, MD 21742                           |
|             |  |                   | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only or | ications that caused the deat                                   | h. Do not ent                | er the mode of dyir   | ng, such as cardiac                         | or respiratory arr                | est,                             | Approximate<br>Interval Between       |
| 1           | hysician   |                   | Immediate Cause (Final disease or condition                                      | New York  | closo                        | X- 10   | Sie 1                                       | cula                              | rdaa                             | Onset and Death                       |
|             | /Medical   |                   | resulting in death)  | Due to (or as a conseq  | uence of):                   | ne co   |   | July                              | D. CIL                           | 7000                                  |
|             | Examiner   | _                 | Sequentially list conditions,  | D   |                              |   |   |                                   |                                  |                                       |
|             | nsit   | Examiner          | if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a conseq  | uence of).                   |   |   |                                   |                                  |                                       |
|             | execu<br>n and<br>ial-tra  | Exai              | that initiated events resulting in death) Last                                   | Due to (or as a conseq  | uence of):                   |   |   |                                   |                                  |                                       |
| 68760,      | death certificate be executed e attending physician and d for use as the burial-transit  | edical            |  | d   |                              |   |   |                                   |                                  |                                       |
| 89          | ng ph  | Medi              | IF FEMALE:   |   |                              |   |   |                                   |                                  |                                       |
| Box         | attending p  | an/I              | 23b. Was decedent pregnant in the past 12 months?                                | 23c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta       | Ideath 3                     | ☐ Ectopic pregnanc  | :y  |                                   | 23d. Date o<br>Month             |                                       |
| 0           | the a  | Physician/M       | 1 □ Yes 2 □ No<br>9 □ Unknown  | 4 ☐ Pregnant at time of c<br>9 ☐ Unknown                        | death 5                      | Other (specify)   |   |                                   | World                            | Day Teal                              |
| ۵.          | law requires that the<br>as been signed by th<br>2 should be detache   |                   | Part In Other significant conditions con   | ntributing to death but not res                                 | ulting in the ur             | nderlying cause giv   | en in Part I.                               | 23e. Did tol                      | bacco use contribu               | te to the cause of death?             |
| Records,    | ulres ma<br>n signed<br>Id be det  | d by              | 1) Progeto   |   |                              |   |   | 1 □ Y€                            | es 2 □ No 3                      | Probably 4 ☐ Unknown                  |
| င္ပ         | w requir   | Completed         | - Son Gooffor  |   |                              |   |   | 24a, Was a                        | n 24b. Wer                       | re autopsy findings available         |
| <b>四</b> ,  | sician: The law<br>certificate has l<br>irector, page 2 s  | duc               |  |   |                              |   |   | autops<br>perforr                 | sy prio<br>med <i>2</i> dea      | r to completion of cause of th?       |
|             | sician: I<br>certifica<br>irector, pa  | Be C              | 25. Was case referred to medical   |   |                              |   | 26. Place of Dea                            | 1 ☐ Yes 2<br>th (Check only on    |                                  | Yes 2□No                              |
|             | this ce<br>al direc  |                   | examiner?<br>1 ☐ Yes 2 No  | lospital:<br>1 ☐ Inpatient 2 ☐                                  | ER/Outpatier                 | nt 3 DOA Oth  | er: 4 🗆 Nursing H                           | ome 5 Reside                      | ence 6 ☐ Other                   | (Specify)                             |
| 0           | Attending Prostoran: It death. ector: After this certific by the funeral director, I   | :uo               | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                                      | 28a. Date of Injury<br>(Month, Day, Year)                       | 28b. Time of<br>Injury       | 28c. Injur<br>Wor   | y at<br>k?                                  | 28d. Describe ho                  | ow injury occurred               |                                       |
| 20          | death.<br>ctor: A<br>y the fu  | cati              | 2 Accident investigation 3 Suicide 6 Could not be                                |   |                              | M 1 🗆   | Yes 2 ☐ No                                  |                                   |                                  |                                       |
| Division of | after d<br>after d<br>Direct<br>d in by  | Certification: To | 4 Homicide determined  | 28e. Place of Injury - At he<br>building, etc. (Specit          | ome, farm, stre<br><i>y)</i> | eet, factory, office  |   | 28f. Location (St<br>City or Town | treet and Number (<br>n, State)  | or Rurai Route Number,                |
| _           | ithin 24 hours after of the Funeral Director of the Fu |                   | 29a, Certifier 1 Certifying Phy  | sician: To the best of my kno                                   | wledge, deatl                | h occurred at the ti  | me, date and place                          | and due to the c                  | cause(s) and mann                | er as stated.                         |
| :           | e nos<br>124 h<br>e Fun<br>letely  | Medical           |  | ner: On the basis of examina<br>and manner stated.              |                              |   |   |                                   |                                  |                                       |
| :           | 트늘 등 문   | Me                | 29b. Signature and title of continue   | 2   |                              | 29c. Licens   | e number                                    | 2                                 | 29d. Date signed (A              | Nonth, Day, Year)                     |
|             | vithin 2 To the comple   |                   |  |   |                              |   | 7/ CM                                       |                                   | (V) (                            | 3 // max 16 1 mg                      |
|             | To With  |                   | / / llax   | 0   |                              |   | 2600  | $\circ$                           | 1 lod                            | 28,000                                |
|             | * * <b>L</b> 0   |                   | 30. Name see address of person who co  | ompleted cause of death (Item                                   | n 23a) (Type,                | Print)  | · 11  | 0 /                               | 1100                             | CS, COS                               |
| ال          | 1 7+1<br>Sta   |                   | 30. Name car address of person who co  | ompleted cause of death (Item  3 (2 4) Au  32 Moistrar's Signer | n 23a) (Type,                | Print) Can Alia   | nie H                                       | cyesto                            | mM                               | 28, 2008                              |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marian Lucille Shifler 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🛣 F 82 Yrs. March 12,1926 Marvland **Director** 215-20-9434 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show at 1 ☐ Yes 2 No must be notified Director Maryland Washington County Hagerstown 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with ō U.S.A. 21795 16025 Plumtree Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 0. 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 à 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Bank Loan Processor 12 traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Foltz Evans Charles Evans ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. MD 21742 1460 Lindsay Lane Hagerstown, Barbara C. Hill-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 4-1-2008 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Atherosileosu **Physician** VEORS. /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2⊌ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 24

State Registrar 29b. Signature and title of certific

Name an

of death (Item 23a) (Type, Print)

M

2008

29c. License number

29d. Date signed (Month, Day, Year)

medical Campus Rd. Hagerstown, MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 27, 2008 5:00 A M Michael Eugene Sand 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard 9514 Quarry Bridge Court Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 17, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1**X** M 2□ F Washington, D.C 220-56-5823 58 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21046 **USA** 9514 Ouarry Bridge Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Galati A. Rudolph Sand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9514 Quarry Bridge Ct. Columbia, MD 21046 Paula Jean Sand/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 DRemoval from State Chesapeake Crematory 103/28/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Wo MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final asce-200 disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an perform Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Residence 6 Other (Specify) 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 × atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed Box 68760. Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

72 hours after

filed within Hygiene.

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event the

**Physician** 

/Medical

Examiner

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Baltimore,

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Certification:

Medical

4 ☐ Homicide

29b. Signature and titl

29a, Certifie

Division or Vital Attending al or Attendi after death. | Director: A To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

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| (4 | $\mathbf{c}$ | ni | <b>7</b> ~ |   |
| V  | ٧/           | W  | /          | • |
| v  | _            |    |            |   |
|    |              |    |            |   |

30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Edelman, MD martin 31. Date filed (Month, Day, Year)

determined

MAR 28

, 205 Greene St. Bathwere, MD 21201 32. Redstrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 March 27, **Physician** 12:10 A M Shirley M. Sewell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🛛 F Maryland 213-28-3689 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No MD Carroll Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 495 Tremont Drive #4 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Klinedinst Carl Tyson Brashears ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12030 Tralee Road #406 Timonium, MD 21093 Georgena Ewing/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 03/28/08 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 $v_{M01251}$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 📉 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autop... performed: 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ MOther (Specify) hospice1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be ury - At home, farm, street, factory, office 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Physician/Medical à

physician and s the burial-trans as the k attending properties of the second ed by the a detached 1 signed by page 2 should certificate |

**Physician** /Medical

Examiner

**Funeral** 

Director

sa or 28a-f show t be notified at

the

Department of Health and Mental Hygiene. In a 15-0036
Important: If item 27 is marked other than "natural" any injury or other traumatic even."

requires that the death certificate be executed P.0. Records, Division or Vital After this funeral ( To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Box 68760,

State Registrar

Medical

29a. Certifier

Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. te basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) mappier stated. 2 ☐ Medical Exam 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

March 27, 2008

stract Libsthiuster, MD 2157

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

ate filed (Month,

MAR 2 8 2008

Certificate of Death

23d. Date of delivery Year Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2X No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1XXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

D52261

MARCH 21, 2008

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Hospital: 1 X Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

1517 HUGO CIRCLE SILVER SPRING, MD 20906 ALAN R. SEGAL, M.D.

31. Date filed (Month, Day, Year State MAR 2 6 2008

1 ☐ Yes 2 XNo

5 ☐ Pending investigation

6 ☐ Could not be

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier



Registrar

State of Maryland / Department of Health and Mental Hygiene

MARYLAND

Black, White, etc.

7:45 P M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 XYes 2 No

Year

Division or Vital Records, P.O. Box 68760,

al or Attending F after death. neral Director: /

Be

Certification: To

Medical

1 - For State Registrar

5. Social Security Number

Usual Residence of Decedent

**\$79-62-7118** 

10a. State

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)
Margarita
P.

4a. Facility Name (If not institution, give street and number)

1 □ M 2√0 F

Southern Maryland Hospital

10b. County

|                 | ylan<br>at  |                               | 10a. State   | 10b. County                       |   | 10c. City, T        | own or Loca    | tion  |                          |                                   |                  |                 |                               |                    | e City Limits                 |
|-----------------|---|-------------------------------|--|-----------------------------------|---|---------------------|----------------|---|--------------------------|-----------------------------------|------------------|-----------------|-------------------------------|--------------------|-------------------------------|
|                 | Mar<br>a-f st<br>fied   | tor                           | Maryland   | Prince Ge                         | orge's  | Temp1               | e Hills        | 3   |                          |                                   |                  |                 |                               | 1 🗆 \              | Yes 2. 14 No                  |
|                 | h the   | irec                          | 10e. Street and Nu   | umber                             |   |                     |                | 10f. Zip Cod                                  | е                        |                                   |                  | 10g. Cit        | izen of What Co               | untry?             |                               |
|                 | h with  | al D                          | 6701 Alle  | entown Road                       |   |                     |                | 20  | 0748                     |                                   |                  | USA             | A                             |                    |                               |
|                 | ms 2  | ner                           | 11. Marital Status   |                                   | 12. Was Decedent Armed Forces?                    | Ever in U.S.        | 13. Wa         | as Decedent o                                 | of Hispanic Or           | rigin? (Specify<br>an, Puerto Ric | Yes or No        | -               | 14. Race - Ame<br>Black, Whit |                    | ٦,                            |
| 9               | after<br>or ite   | F                             | 1 ☐ Never Mar  | ried 2 Married                    | 1 ☐ Yes 2XXII                                     | No                  |                | Tes, specify C                                |                          |                                   | an, etc.,        |                 |                               | e, etc.<br>amanian | 1                             |
| 03              | ral", Exar  | b                             | XX Widowed   | 4 Divorced                        | Year or Dates:                                    |                     |                | _1163 2451                                    | o Specify                |                                   |                  |                 | Specify.                      |                    |                               |
| 5-0036          | 72 hours after death with the Marylan<br>'natural', or items 23a or 28a-f show<br>dical Examiner must be notified at  | etec                          | (Spe   | 15. Decedent's E                  | ducation<br>ade completed)                        | 1                   | 6a. Decede     | nt's Usual Oc<br>nd of work do<br>NOT use rei | cupation<br>ne during mo | st of working                     |                  | 16b. K          | ind of Business/              | Industry           |                               |
| 21              | within<br>iene.<br>than "   | ם                             | Elementary/Sec   |                                   | College (1-4or 5                                  | 5+)                 |                | o not use rei<br>emaker                       | ired)                    | -                                 |                  |                 | In Ha                         | mo.                |                               |
| 2               | filed withir<br>Hygiene.<br>other than<br>ent, the M  | Completed by Funeral Director |  |                                   |   |                     | HORE           | iliakei                                       | 10.14-45                 | ner's Name <i>(F</i>              |                  | A d m i al m    |                               |                    |                               |
| Pu              | be fill<br>tal H<br>d oth<br>even   | B B                           |  | (First, Middle, Las               |   |                     |                |   |                          | ers name <i>(r</i><br>sefa        | Sablar<br>Sablar |                 | i Surname)                    |                    |                               |
| <del>y</del> la | 2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me   | 은                             | Vicente  | Flores                            | Perez   |                     |                |   |                          |                                   |                  |                 | - 0                           |                    |                               |
| Maryland 2121   | s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   |                               |  | Name/Relationship                 |   |                     | -              | •   |                          |                                   |                  | -               | or Town, State, 2<br>2014     |                    |                               |
| 6               | 1 and 2<br>Health<br>em 27 I  |                               |  | S. Link / D                       | augnter   | 20h Plac            |                | tion (Name of                                 |                          | et Asbur                          |                  |                 | ocation - City or             |                    |                               |
| 0               |   |                               | 20a. Method of Dis<br>1xx Burial 2   |                                   | ☐Removal from State                               | cem                 | etery, crema   | itory or other                                | place)                   |                                   |                  |                 |                               |                    |                               |
| Ë               | tmen<br>tant:   | İ                             | //   | 5 Other (Speci                    |   | Arlin               |                | it. Ceme                                      |                          | 04/11/                            |                  |                 | ington, V                     |                    |                               |
| Baltimore,      | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>any Injury or other tr<br>once.   |                               | 21. Signature of F   | Funeral Service Lice              | ensee   |                     | 61             | Name and Ad                                   | uress of Facil           | <sup>nty</sup> George<br>oad Oxon | е Р. Ка<br>Чнат  | llas l<br>Marvi | Funeral H                     | ome P.A<br>0745    | 1.                            |
|                 |   |                               | 13,00  | gain                              | 0 /9/   | data - da - ata - 1 |                |   |                          |                                   |                  |                 | Land 2                        | Approxi            | imate                         |
|                 |   |                               |  |                                   | nplications that caused<br>y one cause on each li | ne.                 | Do not enter   | the mode of                                   | aying, such a            | s cardiac or re                   | espiratory a     | rrest,          |                               | Interval           | Between<br>and Death          |
| Y.              | Physician   |                               | Immediate Cause<br>disease or conditi<br>resulting in death                          | on                                | _a  | Sep 5               |                |   |                          |                                   |                  |                 | 107                           |                    |                               |
| 1               | /Medical<br>Examiner  |                               | resulting in death,  |                                   | Due to (or as                                     |                     |                |   |                          |                                   |                  |                 |                               |                    |                               |
| Ь               | _xammo.   | _                             | Sequentially list o  | onditions,                        | b. Due to (or as                                  |                     | 200 of         | , cr  |                          |                                   |                  |                 |                               |                    | -                             |
|                 | ed sit  | Examiner                      | Sequentially list c<br>if any, leading to i<br>cause. Enter Und<br>Cause (Disease of | mmediate<br>lerlying<br>or injury | Due to (or as                                     | a consequen         | ice ory.       |   |                          |                                   |                  |                 |                               |                    |                               |
|                 | and<br>and<br>I-trar  | xan                           | that initiated even<br>resulting in death)   | ts<br>Last                        | cDue to (or as                                    | a consequer         | nce of):       |   |                          |                                   |                  |                 |                               |                    |                               |
| 60              | be e)<br>ician<br>buria   | al E                          | •  | - 12                              |   |                     | ŕ              |   |                          |                                   |                  |                 |                               |                    |                               |
| 68760,          | phys<br>the   | dic                           |  | •                                 | d   |                     |                |   |                          |                                   |                  |                 |                               |                    |                               |
| ×               | certifi<br>ding<br>se as  | Physician/Medical             | IF FEMALE:   |                                   | 23c. If yes, outcome                              | pf pregnanc         | У              |   |                          |                                   |                  |                 | 23d. Date of de               | livery             |                               |
| Вох             | atten<br>for u  | cian                          | 23b. Was decede<br>in the past 1   | 2 months?                         | 1 ☐ Live birth<br>4 ☐ Pregnant a                  | 2 Fetal de          | eath 3 🗆 E     | ctopic pregna<br>Other <i>(specif</i> y       |                          |                                   |                  |                 | Month                         | Day                | Year                          |
| P.O.            | the d<br>/ the<br>ched  | ysi                           | 1 □ Yes 2<br>9 □ Unknow  | n No                              | 9□Unknown   |                     |                |   |                          |                                   |                  |                 |                               |                    |                               |
|                 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | /Ph                           | Part II. Other sign  | ificant conditions                | contributing to death b                           | ut not resultir     | ng in the und  | lerlying cause                                | given in Part            | 1.                                | 23e. Did 1       | obacco          | use contribute t              | o the cause        | of death?                     |
| sp,             | uires<br>n sign<br>ld be  | d b                           |  |                                   |   |                     |                |   |                          |                                   | 1 🗆              | Yes 2           | !□ No 3□ P                    | robably 4          | 4 Unknown                     |
| ital Records,   | w req<br>beer<br>shou   | Completed by                  |  |                                   |   |                     |                |   |                          |                                   | 24a. Was         | an              | 24b. Were a                   |                    |                               |
| Re              | ne lav<br>e has<br>ge 2   | m<br>d                        |  |                                   |   |                     |                |   |                          |                                   | auto             | psy<br>ormed?   | death?                        |                    | ings available<br>of cause of |
| a               | lan: The law<br>rtificate has l<br>:tor, page 2 s   |                               | 25. Was case refe  | arred to medical                  |   |                     |                |   | 00 Fl-                   | D //                              | 1□ Yes           | 2 N             | 1 □ Yes                       | 2 □ No             |                               |
| ₹               | sicla<br>certi<br>irecto  | Be C                          | examiner?  | Mo                                | Hospital:   | ont 2DER            | l/Outpatient   | 3 🗆 DOA                                       | Otto                     | ce of Death (C                    |                  |                 | 6 □Other (Spe                 | - if .\            |                               |
| or V            | or Attending Physic!<br>ther death.<br>Director: After this cer<br>in by the funeral direct   | : To                          | 27. Manner of Dea  |                                   | 28a. Date of Inju                                 | ırv 28              | Bb. Time of    |   | njury at<br>Work?        |                                   |                  |                 | iry occurred                  | City)              |                               |
| Division        | ding<br>h.<br>Afte<br>fune  | Certification:                | 1 Natural<br>2 ☐ Accident  | 5 ☐ Pending investigation         | (Month, Da  | y Year)             | Injury         |   | Mork?<br>I∐Yes 2∐        | No                                |                  |                 |                               |                    |                               |
| S               | Atten<br>deat<br>ctor<br>y the  | fica                          | 3 ☐ Suicide  | 6 ☐ Could not I                   | 28e. Place of ini                                 | ury - At home       | e, farm, stree | et, factory, off                              | ice                      | 28f                               |                  |                 | nd Number or A                | ural Route         | Number,                       |
| 2               | after<br>Dire   | erti                          | 4 🗌 Homicide   | determine                         | building, et                                      | tc. (Specify)       |                |   |                          |                                   | City or To       | wn, Stat        | e)                            |                    |                               |
|                 | To the Hospital or Attending Physicil within 24 hours after death.  To the Funeral Director: After this cer (completely filled in by the funeral direct   | al C                          | 29a. Certifier   |                                   | hysician: To the best                             |                     |                |   |                          |                                   |                  |                 |                               |                    |                               |
|                 | e Ho<br>124 h<br>e Fui<br>letely  | Medical                       | (Check only one)   | 2 ☐ Medical Exa                   | aminer: On the basis of<br>and manner st          |                     | n and/or inve  | estigation, in r                              | ny opinion, de           | eath occurred                     | at the time      | , date an       | id place, and du              | e to the cau       | use(s)                        |
|                 | Vithin Vithin Co the Complete | Me                            | 29b. Signature an  | d title of certifier              |   |                     |                | 29c. Lic                                      | ense number              | -                                 |                  | 29d. Da         | ate signed (Mon               | th, Day, Ye        | ar)                           |
|                 |   |                               |  | 210                               |   |                     |                | DO  | 063998                   |                                   |                  | 3               | 1251                          | 80                 |                               |
| 0               | 201   |                               | 30. Name and ad-   | dress of person who               | completed cause of c                              | death (Item 2       | 3a) (Type, P   | rint)   |                          |                                   |                  |                 |                               |                    |                               |
| K               | -67   |                               | Manesh N   |                                   | D 7503 Surr                                       |                     |                |   | vland '                  | 20735                             |                  |                 |                               |                    |                               |
|                 | St  | ate                           | 31. Date filed (Mo   | onth, Day, Year)                  | 22 Rogistr  | rar's Signatur      | P-             |   | ,                        |                                   |                  |                 |                               |                    |                               |
|                 | Regist  | rar                           | MAR  | 2 6 2008                          | Blend   | K B                 | sere!          |   |                          |                                   |                  |                 |                               |                    |                               |
| DH              | IMH 17 Rev 1/2  | 2001                          |  |                                   |   |                     |                |   |                          |                                   |                  |                 |                               |                    |                               |
|                 |   |                               |  |                                   |   |                     | ORIG           | INAL  |                          |                                   |                  |                 |                               |                    |                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months Days

4b. City, Town, or Location of Death

Clinton If Under 1 Year | If Under 24 Hrs.

Sablan

7. Age (In yrs. last birthday)

10c. City, Town or Location

84

Reg. No.

4c. County of Death

Prince George's

2:10 A

Birthplace (State or Foreign Country)
 Charm

Guam

10d. Inside City Limits

2. Date of Death March 25, 2008

8. Date of Birth Feb. 23, 1924

|           |  |                     | 1 - For State Registrar  | State of M  | Marylan  |                                  | artment<br>rtificate                       |                   |                            | ind M           | F                                  | Reg. No.                | 008                             | 11799   |
|-----------|--|---------------------|--|---|--|----------------------------------|--|-------------------|----------------------------|-----------------|------------------------------------|-------------------------|---------------------------------|---|
|           | Physici<br>/Medio  |                     | Decedent's Name (First, Middle,     Sue Keener Th  |   |  |                                  |  |                   |                            |                 | 2. Date of Dea                     | Day                     | Year<br>08                      | 3. Time of Death 6:30 PM                        |
|           | Examin   |                     | 4a. Facility Name (If not institution, Northampton M   |   | -  | Caro                             | 4b. City, T                                |                   | Location o                 | f Death         |                                    | 4c. C                   | County of Death                 | 1   |
|           | Funeral  |                     |  | 3. Sex 7. /   | Age (in yrs.   | last birthday)                   | II Under 1                                 |                   | If Under 2                 | 24 Hrs.<br>Min. | 8. Date of Birth                   | h                       | 9. Birth                        | nplace (State or Foreign                        |
|           | Director   |                     | 555-32-3537 Usual Residence of Decedent  | 1□M 2[X]F   | 86   | Yrs.                             | Monard                                     | Duys              | 110013                     |                 | 1 / 28 / 2                         | 22                      | Mob                             | oile AL   |
|           | show   | 5                   | 10a. State 10b. County MD Frede  | rick  |  | y, Town or Lo                    |  |                   |                            |                 |                                    |                         |                                 | 10d. Inside City Limits  1√ Yes 2 No            |
|           | deeth with the Maryland<br>me 23a or 28a-f show<br>r must be notified at   | Funeral Director    | 10e. Street and Number   |   |  |                                  | 10f. Zip 0                                 |                   |                            |                 |                                    |                         | en of What Co                   | 21  |
|           | eeth wi  | erai                | 100 Burgess H  | Lll Way   | at Ever in II  | S 13 1                           |  | 702               |                            | nin? (Sne       | ofu Vae or No-                     |                         | SA<br>4. Race - Amer            | ican Indian                                     |
| 030       | be filed within 72 hours after deeth with the Marylan at all tygien.  All tygien.  All tygien.  All the Medical Examinar must be notified at event, the Medical Examinar must be notified at   | þ                   | 11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced   | Armed Force   | s?<br>∃No  |                                  | Yes, specifi<br>1 ☐ Yes 2                  | fy Cubar          | Specify:                   | , Puerto I      | cify Yes or No-<br>Rican, etc.)    |                         | Black, White                    | e, etc.   |
| 9500-C    | natura<br>"natura  | eted                | 15. Decedent's (Specify only highest   | Education grade completed)                                    |  | 16a. Dece                        | dent's Usual<br>kind of work<br>DO NOT use | Occupa<br>done di | tion<br>uring most         | of workii       | ng                                 | 16b. Kind               | d of Business/I                 | ndustry   |
| 7 7       | e filed within al Hygiene.   | Completed           | Elementary/Secondary (0-12)  | College (1-40<br>2  | r 5+)  |                                  | ewife                                      |                   | Cler                       |                 |                                    | Hor                     | memake                          | er  |
| yland     | 2 should be file<br>o and Mental Hy,<br>is marked other<br>raumatic event,   | To Be C             | 17. Father's Name (First, Middle, La<br>Clarence Rupe  |   | er   |                                  |  |                   |                            |                 | (First, Middle, tton A             |                         | •                               |   |
| Mar       | iges 1 end 2 should<br>nt of Heelth and Mer<br>if Item 27 is marke<br>or other traumatic   |                     | 19a. Informant's Name/Relationshi Jeffrey Thomas   |   |  |                                  |  |                   |                            |                 | Route Numbe                        |                         |                                 |   |
| Je,       | of Heel<br>of Heel   |                     | 20a. Method of Disposition   |   | 20b. F   | Place of Dispo<br>cemetery, crer | _  |                   | -                          |                 | ate                                |                         | ation - City or                 |   |
| Баппто    | permit. Pages 1 end:<br>Department of Heelth<br>Important: If Item 27<br>eny injury or other tr.<br>2002.  |                     | 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe   | city)   | /a   | gerst                            | own C                                      | rem               | ı. 3                       | 3/27            | /08                                | Hage                    | erstow                          | n MD  |
| ğ         | Depa<br>Impo   |                     | 21. Signature of Funeral Service Li  | AWIR  | rois   |                                  | Name and ohn T                             |                   | ,                          |                 | Funera                             | il Hi                   | M Brun                          | s. MD   |
|           | Physician /Medical Examiner  | Examiner            | 23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a   | as a conseques a conseques a conseques a conseques a conseques a conseques a conseques a conseques a consequence a | uence of):                       |  | , ,               |                            |                 | hlmone                             |                         | Di} enge                        | Approximate Interval Between Onset and Death    |
| 00/00 200 | To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical E | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 menths?   | d   | 2 Feta   | death 3                          | Ectopic preg                               |                   |                            |                 |                                    | 23                      | 3d. Date of deliment            | very<br>Day Year                                |
| <i>i</i>  | by the drached   | hysic               | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□ Unknown  |  | oau J                            | TOTTET (Spec                               |                   |                            |                 |                                    |                         |                                 |   |
| L Sp.     | equires the  | þ                   | Part II. Other significent condition   | s contributing to death                                       | but not res  | ulting in the u                  | nderlying cau                              | use give          | n in Part I.               |                 | 23e. Did to                        | bacco usi<br>6s 2 🗆     |                                 | the cause of death?                             |
| וו שבנסו  | Physician: The law requires that the the this certificete has been signed by the rail director, page 2 should be detached.   | Completed           | Mype Hen   | Mellita   | 57   | DISE                             | 15C  |                   |                            |                 | 24a. Was a autop perfor            | sy                      | prior to c<br>death?            | topsy findings available completion of cause of |
| N II      | s certifi  | To Be               | 25. Was case reterred to medical examiner?  1 Yes 2540   | Hospital: 1 ☐ Inpa  | tient 2  | ER/Outpatien                     | * 3D DOA                                   | Otho              |                            |                 | (Check only of                     |                         | Other (Sac                      | 4.1   |
|           | ing Phy<br>Viter thi<br>uneral o   |                     | 27. Manner of Death  Natural 5 ☐ Pending   | 28a. Date of in<br>(Month, L                                  |  | 28b. Time of<br>Injury           | 280  | c. Injury<br>Work | at<br>?                    | 2               | 28d. Describe h                    |                         |                                 | ну)   |
| DINISIO   | or Attendi<br>after death.<br>Director: A<br>in by the fi  | Certification:      | 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin  | t be 28e. Place of I  | njury - At ho  | ome, larm, str                   | eet, factory,                              |                   | es 2□N                     |                 | 281 Location (S<br>City or Tow     |                         | Number or Ru                    | ral Route Number,                               |
|           | To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune  | Medical Co          | 29a. Certifier Certifying (Check only 2 Medical Ex   | Physician: To the best<br>raminer: On the basis<br>and manner | of examina   | wledge, death                    | occurred at<br>vestigation, in             | t the time        | e, date and<br>inion, deat | d place, a      | and due to the dead at the time, d | ause(s) a<br>date and p | and manner as<br>place, and due | stated.<br>to the cause(s)                      |
|           | To th<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier  |   | 1  | ,                                | 29c.                                       | License           | number                     | ,/              | 20                                 | 29d. Date               | signed (Month                   | , Day, Year)                                    |
|           | .  |                     | 30. Name and address of person w   | no completed cause of   | death (Item  | n 23a) (Typa                     | Print)                                     | )                 | 0/4                        | 040             | 40                                 |                         | 5/27                            | 108   |
|           | V  |                     | CASPER E. CL   | WE NO.  | 300  | ow.                              |  | 45                | 7                          | FER             | DECO                               | ( )                     | 40 7                            | 1701  |
|           | Sta<br>Registr   | _                   | 31. Date filed (Month, Day, Year)  | 2 8 2008  | strø's Signa   | iture &                          |  | 1                 |                            |                 |                                    |                         |                                 |   |

Physi /Me Exar Jatient Known as Charles Thomas **Funer** Direct permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physicia /Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

|  | 0  |  |  |
|--|--|--|--|
| For State  | State of Maryl   | and / Department of Health and   | Mental Hygiene   |
| Registrar  1. Decedent's Name (First, Middle   | Logi   | Certificate of Death   | Reg. No.   |
| Charles Stanle   | ,  |  | 2. Date of Death Month Day Year  March 2008 8 '34 F  |
| 4a. Facility Name (If not institution  | 7  | 4b. City, Town, or Location of Dea   | The state of the s |
| Sinai Huspit   | al of balt   | imore Gultimore  | City   |
| 5. Social Security Number  | 6. Sex 7. Age (In  | yrs. last birthday) If Under 1 Year   If Under 24 Hrs<br>Months Days Hours Min   |  |
| 578-78-2920  | 51   | Yrs. World Days Hours  | July 29, 1956 Washington D.  |
| Usual Residence of Decedent  10a. State 10b. County  | 100  | . City, Town or Location   | 10d. Inside City Lin   |
|  |  | . ory, form of Location  | 1 ☐Yes 2 🖸   |
| Maryland Cari  | coll N   | Mt. Airy 10f. Zip Code   |  |
|  | -  |  | 10g. Citizen of What Country?  |
| 802 Merridale Bl   | 12. Was Decedent Ever i  | n U.S. 13 Was Decedent of Hispanic Origin? (5  | United States  Specify Yes or No- 14. Race - American Indian,  |
| 1 ☐ Never Married 2 🔀 Marrie   | Armed Forces?  | in U.S. 13. Was Decedent of Hispanic Origin? (\$\) If Yes, specify Cuban, Mexican, Puer  | rto Rican, etc.)  Black, White, etc.   |
| 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 ☑ No Specify:  | Specify: Black   |
| 15. Decedent   | s Education  | 16a. Decedent's Usual Occupation   | 16b. Kind of Business/Industry   |
| (Specify only highes Elementary/Secondary (0-12)   | College (1-4or 5+)   | (Give kind of work done during most of wo  | orking   |
|  | 4  | Auto Claims Adjuster   | Insurance  |
| 17. Father's Name (First, Middle, L  | .ast)  |  | me (First, Middle, Maiden Surname)   |
| Charles Emory Th   | omas_  | Elsie F  | Bernice Gillus   |
| 19a. Informant's Name/Relationsh   | ip (Type. Print)   |  | Pural Route Number, City or Town, State, Zip Code)   |
| Susan Thomas/ W  | life   | 802 Merridale Blvd. M  | Mt. Airy, Maryland 21771   |
| 20a. Method of Disposition   |  | b. Place of Disposition (Name of cemetery, crematory or other place)   | Date 20c. Location - City or Town, State   |
| 1 ☐ Burial 2 ☑ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp   |  | i i  | 26/2008 Frederick, Maryland.   |
| 21. Signature of Juneral Service L   | icensee  | 22. Name and Address of Facility<br>Stauffer Funeral H   | 20/2000 Flederick, Maryland.   |
| Sodil Y  | MMIN   | 1621 Opossumtown P   | omes P. A.<br>Pike, Frederick, Maryland 217  |
| 23a. Part1. Enter the disease, or  | complication at caused the d   | leath. Do not enter the mode of dying, such as cardia  | ac or respiratory arrest, Approximate Interval Between   |
| shock, or heart failure. List of<br>Immediate Cause (Final   | only one cause on each line.   |  |  |
| disease or condition   | 44211  | 2000 makes Dictors   | Interval Between<br>Onset and Death  |
| resulting in death)  | a. Hout  | Respiratory Distres  | Syndrome 29 day  |
| resulting in death)  | Due to (or as a control of the contr | Respiratory Distres  | Syndrome 29 day  |
| resulting in death)  | a. Due to (or as a conduct to b. De Co (fi (a) Due to (or as a conduct to (or a conduct to (or  | tion of chronic lo   | Syndrome 29 day<br>culated left 4 month  |
| resulting in death)  | . Decortica  | tion of chronic lo   | Syndrome 29 day<br>culated left 4 month  |
|  | . Decortica  | tim of Chronic los<br>etenum Tuberculus  | Syndrome 29 day<br>culated left 4 month  |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b. De co (fi (a<br>Due to (or as a cons  | tim of Chronic los<br>etenum Tuberculus  | Syndrome 29 days   |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. De co (fr as a cons   | tim of Chronic los<br>etenum Tuberculus  | Syndrome 29 days   |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b. De Co (fi Co) Due to (or as a const c. Due to (or as a const d. 23c. If yes, outcome pf pre   | sequence of):  Tuberculus  sequence of):   | Syndrone 29 day<br>culated left 4 month<br>pleural effusion<br>ins   |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | b. De CO (fi C) Due to (or as a constant of the constant of th | sequence of):  Tuberculus  sequence of):  gnancy  etail death 3   Ectopic pregnancy  | Syndrome 29 day<br>culated left 4 month  |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant   | b. De Co (fi on Due to (or as a constant of Due to (or as  | sequence of):  Tuberculus  sequence of):  gnancy  etail death 3   Ectopic pregnancy  | Syndrone 29 day culated left 4 month pleural effusion unknow 23d. Date of delivery   |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | b. De to (or as a constant of the following of the follow | sequence of):  Tuberculus  sequence of):  gnancy  etail death 3   Ectopic pregnancy  | Syndrone 29 day  culated left 4 month  pleural effusin  unknow  23d. Date of delivery  Month Day Year  |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | b. De to (or as a constant of the following of the follow | sequence of):  Sequen | onset and Death 29 day and Culated left 4 month of the Pleural effusion who we will be a seen and peath of the cause of death?   |
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| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | b. De to (or as a constant of the following of the follow | sequence of):  Sequen | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown and topsy performed?   |
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| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No  | b. De to (or as a constant of the constant of  | sequence of):  Sequen | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown autopsy Derformed? 1 Yes 2 No 1 Yes 2 No  24a. Was an autopsy Derformed? 1 Yes 2 No 1 Yes 2 No  ath (Check only one)   |
| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  CULC   Revenue   Reven | b. De to (or as a constitution of the contributing to death but not the contribution of the contribution o | sequence of):  Sequen | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown at the completion of cause of death?  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   Yes  |
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| resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | b. De to (or as a constitution  b. De to (or as a constitution  c. De to (or as a constitution  De to (or as a constitution  De to (or as a constitution)  Constitution  De to (or as a constitution)  De to (or as a constitution)  A pregnant at time of the constitution  De to (or as a constitution)  De to (or as a constitution)  A pregnant at time of the constitution  De to (or as a constitution)  De to (or as a constitution | sequence of):    Comparison   C | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown to completion of cause of death?  124a. Was an autopsy performed? 12 Yes 2   No 1   Yes 2   No ath (Check only one)  1   Yes 2   No ath (Check only one)  28d. Describe how injury occurred  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  OF OF OF OF OF OF OF OF OF OF OF OF OF O  | b. De to (or as a constitution  b. De to (or as a constitution  c. De to (or as a constitution  De to (or as a constitution  De to (or as a constitution)  Constitution  De to (or as a constitution)  De to (or as a constitution)  A pregnant at time of the constitution  De to (or as a constitution)  De to (or as a constitution)  A pregnant at time of the constitution  De to (or as a constitution)  De to (or as a constitution | sequence of):    Comparison   C | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown at the completion of cause of death?  24a. Was an autopsy performed? 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   Yes  |
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| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  Of UHC Ref.  25. Was case referred to medical examiner? 1   Yes 2   No 27. Manner of Death 1   Natural   5   Pending investigated   Pending investigated   Pending  | b. De Co (from the completed cause of death (it is a completed cause of de | sequence of):    Comparison   C | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  CUL   Rev.   Part    | b. De to (or as a condition of the best of my laxaminer: On the basis of examinant and manner stated.  | sequence of):    Comparison   C | 23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4   Unknown death?  2   Yes 2   No 3   Probably 4    |

Regis DHMH 17 Rev 1/2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 MARCH 23, **Physician** JESSYE H. TOGBA 9:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG. 9, **Funeral** 9. Birthplace (State or Foreign Days Min. 1 □ M 2 K F Hours 058-22-0416 92 PENNSYLVANTA 1915 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. net of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sh Exaπiner must be notified Director MD 1 X Yes 2 □ No MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4050 ADAMS DR 20902 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 🛣 No Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTED NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN TRENT ALICE BUTLER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN TOGBA/DAUGHTER 4050 ADAMS DR., SILVER SPRING, MD. 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 4/5/08 ROCKVILLE, MD. 21. Signature of Funeral Service Lice 22. Name and Address of Facility CAPITOL MORTUARY INC. 1425 MARYLAND AVE., N.E. WASHINGTON, D.C. 20002 23a. P.111. Enter the disease s ock, or heart failure. plications that caused the death. Delly one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending | 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 TNo 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AMPULLARY CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No P 1 🔲 Inpatient 2√ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and tittle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ROBERT BOTHSTEIN MD. 8600 OLD GEORGETOWN RD. BETHESDA, MD. 20814 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 2 6 2008



1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |  |                      | For State Registrar   | State of Mary  | land / Depa                                     |  | ealth and M                            | lental Hygi  | _                             | 08  | 11803   |
|--------------------------------|--|----------------------|---|--|---|--|--|--|-------------------------------|---|---|
|                                | Physici<br>/Medic  | an                   | 1. Decedent's Name (First, Middle, Last  Jewel A. Vandeva   | nder   |   |  | Landing of Darah                       | 2. Date of Death<br>Month<br>MAP-U                 | 23                            | Year<br>200 B   | 3. Time of Death                              |
| 1                              | Examin<br>Funeral<br>Director  | Ų.                   | 4a. Facility Name (If not institution, give  Anne Arundel Medi  5. Social Security Number  577–48–7021  | cal Center   | yrs. last birthday)<br>Yrs.                     | Annapo If Under 1 Year Months Days   |  | 8. Date of Birth<br>(Month, Day,<br>2/13/1         | Anne                          | Arunde  | e1<br>ice (State or Foreign<br>V)<br>Virginia |
|                                | Maryland -f ehow   | tor                  | Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru  |  | c. City, Town or Lo                             |  | dgewater                               |  |                               | 100   | d. Inside City Limits                         |
| 36                             | be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examinat must be notified at | by Funeral Director  | 10e. Street and Number  87 Stewart Drive,  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | Unit 320  12. Was Decedent Ever Armed Forces?  1 XYes 2 □ No ff Yes, Give Year or Dates: 192   |   | 10f. Zip Code 2103 Was Decedent of Hi If Yes, specify Cubar 1 \( \tag{Y} \) Yes 2\( \text{\$k\$} \) No |  |  | 14. Ra                        | What Countr<br>USA<br>Ice - America<br>ack, White, et<br>ify: Whi | n Indian,<br>tc.                              |
| Baltimore, Maryland 21215-0036 | filled<br>Hygi<br>Sther<br>ent, I  | Be Completed         | 15. Decedent's Edit (Specify only highest grad Fementary/Secondary (0-12) 7th  17. Father's Name (First, Middle, Last)  | ucation  | 16a. Dece<br>(Give<br>life.                     | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired,<br>houseman                         | furing most of work ) 18. Mother's Nam | e (First, Middle, M                                | Cold                          | Storago<br>Storago  |   |
| , Marylar                      | should<br>and Mer<br>smarks<br>aumatic   | To E                 | Oral Vand  19a. Informant's Name/Relationship (7)  M. Faye Vandevand  | ype, Print)<br>ler/ Wife   | 87 S  | ng Address (Street a   | and Number or Rui                      | 320, Edge  | City or Town                  | , MD 2  | 1037  |
| Baltimore,                     | permit. Pages 1 and 2<br>Department of Health<br>Important: If Item 27 I<br>eny injury or other tra<br>905e.   |                      | 20a. Mathod of Disposition  1 \( \text{D}\) Burial 2 \( \text{Cremation} \) 3 \( \text{d}\)  4 \( \text{Donation} \) 5 \( \text{Other} \) (Specify  21. Signat  | ) I  | MD Vetera                                       | osition (Name of<br>matory or other place<br>ans Cemete<br>2. Name and Addres<br>973 Solom             | ery 3/27                               | 7/08 orge P. K                                     | Chelte<br>Calas               |   | MD<br>1 Home                                  |
| 4                              | Physician /Medical buyaicien and physicien and physicien and physicien and physicien are the partial-transit   | cal Examiner         | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b  | onsequence of):                                 | ter the mode of dyin   | g, such as cardiac                     | or respiratory arre                                | st,                           |   | Approximate interval Between Onset and Death  |
| . Box 68                       | ne death certif<br>the attending<br>thed for use as  | Physician/Medic      | fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | d  | Fetal death 3                                   | □Ectopic pregnancy □ Other (specify)   |  |  |                               | Date of deliver   | y<br>Day Year                                 |
| ords, P.O                      | w requires that the bean signed by should be detact  | by                   | Part ff. Other significent conditions of  | entributing to death but no  | ot resulting in the u                           | underlying cause give  | en in Part I.                          |  | acco use co<br>s 2 \( \sum No |   | e cause of death?                             |
| al Records,                    | icien: The law r<br>certificate has be<br>ector, page 2 sh   | e Completed          | 25. Was case referred to medical  |  |   |  | 26 Place of Dea                        | 24a. Was ar autopsy perform 1 Yes 2                | No No                         | prior to com<br>death?  | sy findings available notetion of cause of    |
| Division of Vital              | Phys<br>rthis<br>raldir  | Certification: To Bo | examiner?  1 Yes 2 Oo  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   |  |   | of 28c. Injun<br>Worl<br>M 1   | er: 4 ☐ Nursing H                      | ome 5 ☐ Reside 28d. Describe ho 28f. Location (Str | nce 6 C<br>w injury occ       | urred   |   |
| Div                            | Hospitel or A hours after Funerel Dire   | Medical Certif       | 4 Homicide determined  29a. Certifier 1 Certifying Ph   | building, etc. (S<br>ysician: To the best of mainer: On the basis of example and manner stated | Specify)  ny knowledge, dea amination and/or in | th occurred at the tin   |  | City or Town                                       | , State)<br>luse(s) and i     | manner as sta   | ated.   |
|                                | To the complete  | Me                   | 29b. Signature and title of certifier  30. Name and address of person who   |  |   | 29c. Licens  |  |  |                               | ned (Month, E   | 0ay, Year)<br>2, 2008<br>olin Md 244          |
|                                | St.<br>Regist  | ate<br>rar           | 4   | 2 A HAN  32. Pogistrar's   | AAMC  |  | nedia                                  | l farter   | vay,                          | Annap   | our prod 214                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MARCH 18, 2008 8:25 A DOROTHY WALLACE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES 6301 DANNER DRIVE CLINTON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF 73 Director 09/30/1934 VIRGIŃIA 226-40-2942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD PRINCE GEORGES LAUREL 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9010 BRIARCROFT LANE APT.#227 20708 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE OFFICE MANAGER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be file spartment of Health and Mental H portant: If Item 27 is marked oth ly Injury or other traumatic even Be KATIE E. GOLEY DEWEY MATHES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6301 DANNER DRIVE CLINTON, MD 20735 ANGELA MCFADDEN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or HARMONY MEMORIAL PARK03/24/2008 LANDOVER, MD 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 MONTHS Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as the attending IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9□Unknowr 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ as been signal 2 should b 1X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an has autopsy performe 1 Yes 2 X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (SpecifyADDRESS 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 ☑Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours efter death To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

SAJEER ANAND, M.D. 7343-A HANOVER PARKWAY GREENBELT, MD 20770 31. Date filed (Month, Day, Year)
MAR 2 8 2008

29b. Signature and title of

certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

March 27, 2008

|                            |  |                         | For<br>State<br>Registrar  | State of Ma   | -  | epartmei<br><i>Certifica</i>                  |                   |   | d Ment       |   | ene<br>g. No. 2 () (        | 36                         |                                    | 805                         |
|----------------------------|--|-------------------------|--|---|--|---|-------------------|---|--------------|---|-----------------------------|----------------------------|------------------------------------|-----------------------------|
|                            | Physici<br>/Medic  | _                       | 1. Decedent's Name (First, Middle, La<br>RAE L. WILES  | st)   |  |   |                   |   |              | ate of Death<br>North<br>RCH                  | 9, 200                      | Year<br>18                 |                                    | of Death P                  |
|                            | Examir   | 3                       | 4a. Facility Name (If not institution, giv<br>455 ELM CROFT I  |   |  |   | , Town, o         | r Location of D                         | eath         |   | 4c. County of               |                            | RY                                 |                             |
| . <u>w</u>                 | Funeral<br>Director  |                         | 223 23 3420  | Sex 7. Age<br>I∏M 2∐XF  | e (In yrs. last birtl<br>73 Y              | Months  | er 1 Year<br>Days | If Under 24<br>Hours                    | vin. (f      | Pate of Birth<br>Month, Day,                  | Year)<br>, 1934             | Coun                       | olace (State<br>otry)<br>.IBER     | e o <i>r Foreign</i><br>IA  |
|                            | ne Maryland<br>8a-f show<br>ptified at   | ctor                    | Usual Residence of Decedent  10a. State  | ERY   | 10c. City, Town                            | VILLE   |                   | • |              |   |                             |                            | 1 <b>X</b> )Y                      | City Limits<br>es 2 □ No    |
| -0036                      | is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  If Health and Mental Hygiene.  If marked other than "natural", or items 23a or 28a-f show items 71 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  | ted by Funeral Director | 10e. Street and Number  455 ELM CROFT BI  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's E  | 12. Was Decedent I<br>Armed Forces?<br>1  Yes 2 N<br>If Yes, Give<br>Year or Dates: | No 16a. I                                  | 13. Was Dece                                  | 2 No              |   |              | Yes or No-<br>n, etc.)                        |                             | - Americ<br>, White,<br>BI | ean Indian,<br>etc.<br>LACK        |                             |
| N                          | ed within 73<br>lygiene.<br>ner than "ni<br>it, the Medi   | Completed               | (Specify only highest gr.  | College (1-4or 5  | +)   | (Give kind of w<br>life. DO NOT (             |                   | EL MANA                                 | AGER         |   | PRIVATE                     |                            |                                    |                             |
| Maryland                   | 2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, the Mental than the manalic event, the Mental than the Mental than the Mental than Mental th | To Be                   | 17. Father's Name (First, Middle, Last<br>GEORGE BREWER  |   | 405  | Marillan Andrea                               |                   | ANGELI                                  | ENE JO       | OHNSON  |                             |                            | 0.10                               |                             |
| aĵ<br>oĵ                   | permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once.   |                         | 19a. Informant's Name/Relationship ( BRENDA WILES/DAUC  20a. Method of Disposition   □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□  | SHTER  Removal from State   | 20b. Place of cemetery                     | 5 ELM C<br>Disposition (Na<br>V, crematory or | ROFT              | BLVD #                                  | 7101<br>Date | ROCKV 2                                       | CEDMANIT                    | D. 2<br>Dity or To         | 20850<br>own, State                |                             |
| Baltimore,                 | permit. Pages: Department of I Important: If ite any Injury or of  |                         | 4 Dolation 5 Other (Special Signature of Funeral Service Uce   |   | elley                                      |   | and Addre         | ss of Facility                          |              | PITOL   | GERMANT<br>MORTUAR<br>ASH D | Y IN                       | IC.                                | 2.                          |
|                            | requires that the death certificate be executed  Washington by the attending physician and and action only be detached for use as the burial-transit   | dical Examiner          | shock, or heart failure. Lift only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. CARC Due to (or as a   | ie.  | OF PANC                                       |                   |   |              |   |                             |                            | Approxin<br>Interval E<br>Onset ar | Between and Death           |
| O. Box 6                   | ires that the death certific<br>signed by the attending p<br>d be detached for use as  | Physician/Med           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  | 23c. If yes, outcome<br>1 ☐Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown             | 2 Fetal death                              | 3 ⊟Ectopic p<br>5 ⊟ Other (s                  |                   | /                                       |              |   | 23d. Date<br>Mon            |                            | ery<br>Day                         | Year                        |
| ords, P.                   | w requires that to be the signed by should be detact   | by                      | Part II. Other significant conditions  | contributing to death bu  | ut not resulting in                        | the underlying                                | cause giv         | en in Part I.                           |              | 23e. Did toba                                 | acco use contri             | bute to th                 |                                    | of death?<br>□Unknown       |
| al Reco                    | ≥ □ ☑  | Completed               |  |   |  |   |                   |   | _            | 24a. Was an<br>autopsy<br>perform<br>1□ Yes 2 | 24b. W<br>pr<br>pd? do      | aath?                      | psy findin<br>mpletion o<br>2 X No | gs available<br>of cause of |
| Or VIE                     | ng Physician:<br>ter this certific<br>neral director,  | n: To Be                | 25. Was case referred to medical examiner?  1 ☐ Yes 2X No  27. Manner of Death  1X Natural 5 ☐ Pending   | Hospital:<br>1  Inpatie<br>28a. Date of Inju<br>(Month, Da)                         | ry 28b. Ti                                 | patient 3 Di                                  | OA Oth            | 4 □ Nursii                              | ng Home      | 5 XResider                                    | nce 6 Othe                  | · · ·                      | fy)                                |                             |
| Division or Vital Records, | I of the Hospital or Attending Physician: The la within 24 hours after death. Within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | Certification:          | 1 Natural 5  | e 280 Place of init   | ıry - At home, farı                        | М   | 1 🗆               | Yes 2□No                                | 28f. L       | ocation (Str.<br>City or Town,                | eet and Numbe<br>State)     | r or Rura                  | al Route N                         | lumber,                     |
|                            | I o the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I  | Medical C               |  | nysiclan: To the best of miner: On the basis of and manner sta                      | examination and                            |   |                   |   |              |   |                             |                            |                                    | se(s)                       |
| )                          | To the within: To the Comple   | Me                      | 29b. Signature and title of certifier  | ley no  |  |   | D252              | e number<br>32                          |              | 29  | d. Date signed 3/24/0       | (Month,                    | Day, Year                          | r)                          |
|                            | Sta<br>Registr   |                         | DR. JOHN ALLOTEY 31. Date filed (Month, Day, Year) MAR 2 8 2008  | 12450   | eath (Item 23a) (1 PARKLAW) ar's Signature | N DR.   | #102              | ROCKV1                                  | LLE,         | MD.   | 20852                       |                            |                                    |                             |

MAR 2 8 2008

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22, 2008 David Wendell Wright March 12:13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Annapolis** Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 3, 1932 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** X1X M 2□ F 026-26-9460 Massachusetts Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes XX No Funeral Director Anne Arundel Maryland Arno1d 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 United States 161 Rugby Road 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 177 yes 2 No If Yes, Give 1954–56 Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Entrepreneur Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marantha Patton Frederick Wright ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Rugby Road Arnold, Maryland 21012 Nancy S. Wright / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Control of the C Baltimore, Maryland Baltimore Crematory 3/25/2008 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 25 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N ဥ 2 ER/Outpatient 3 DOA inpatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: 24 the

Medical .0 State

31. Date filed

29b. Signature and title of certified

30. Name and address of person

(Month, Day, Year)

29a, Certifier

and manner stated

ho completed cause of death (Item 23a) (Type, Pri

gistrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

|                            |  |                     | For<br>State<br>Registrar   | State of Ma   | ryland /                  |                         | rtment o                                    |                    |  |   | giene<br>Reg. No.            | 000                                     | . 1007   |
|----------------------------|--|---------------------|---|---|---------------------------|-------------------------|---|--------------------|--|---|------------------------------|---|--|
| ī.                         | 3000   |                     | Decedent's Name (First, Middle, Last)   |   |                           |                         |   |                    |  | 2. Date of De                           | ath                          |   | 3. Time of Death                                   |
|                            | Physicia<br>/Medic   |                     | George H. Weitze  | el  |                           |                         |   |                    |  | Month<br>03                             | Day<br>2                     | 08                                      | 2215 M   |
|                            | Examin   |                     | 4a. Facility Name (If not institution, give st  | reet and number)  | 1 1                       | H                       | 4b. City, Tov                               | vn, or Local       | tion of Death                              |   |                              | nty of Death                            |  |
|                            | Funeral<br>Director  |                     | 5. Social Security Number 6. Sex  |   | e (In yrs. last i         | birthday)<br>Yrs.       | If Under 1 Y<br>Months D                    | ear If Ui          | nder 24 Hrs.<br>urs Min.                   | 8. Date of Bir<br>(Month, Da<br>Dec. 1. | th<br>ay, Year)<br>5, 1928   | Cou                                     | place (State or Foreign<br>ntry)<br>nsylvania      |
|                            | w  |                     | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, To             | own or Lo               | cation                                      |                    |  |   |                              |   | 10d. Inside City Limits                            |
|                            | Maryla<br>f sho<br>led at  | ō                   | MD Wicomico   |   | Sali                      |                         |   |                    |  |   |                              |   | 1 ☐ Yes 2 X No                                     |
|                            | r 28a-<br>notif  | irect               | 10e. Street and Number  |   |                           |                         | 10f. Zip Co                                 | ode                |  |   | 10g. Citizen                 | of What Cou                             | ntry?  |
|                            | th with  | al D                | 1101 S. Schumaker   | Drive, A  | pt. 00                    | 7                       | 21  | 1804               |  |   | USA                          |   |  |
| 21215-0036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status 1:  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced                           | 2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates: |                           | '                       | Was Deceden<br>f Yes, specify<br>I ☐ Yes 2X | Cuban, Me          | c Origin? (Spe<br>exican, Puerto<br>ecify: | ecity Yes or No<br>Rican, etc.)         | E                            | lace - Ameri<br>lack, White<br>cify: Wh |  |
| 5                          | 72 ho<br>natur<br>lical I  | eted                | 15. Decedent's Education (Specify only highest grade  |   | 16                        | (Give                   | lent's Usual C                              | done durina        | most of work                               | ina                                     | 8                            | Business/Ir                             |  |
| 2                          | /ithin<br>ne.<br>han "   | Completed by        | Elementary/Secondary (0-12)   | College (1-4or 5  | +)                        | life. L                 | oo NOT use r<br>oresent                     | etired)            |  |   |                              | ctrica                                  |  |
|                            | filed v<br>Hygie<br>ther t   |                     | 17. Father's Name (First, Middle, Last)   | 4   |                           |                         | or cocin                                    |                    |  | (First, Middle                          |                              | ıfactu<br>name)                         | rers   |
| au                         | id be<br>ental<br>ked o  | To Be               | George H. Weitzel   | , Sr.   |                           |                         |   | i i                |  | Willia                                  |                              | ,                                       |  |
| Maryland                   | should I<br>and Men<br>s marke   | -                   | 19a. Informant's Name/Relationship (Typ   | e. Print)   | 1                         | 9b. Mailir              | g Address (S                                | treet and N        | umber or Rura                              | al Route Numb                           | oer, City or Tov             | vn, State, Zi                           | p Code)  |
|                            | and 2<br>ealth a<br>n 27 Is<br>er trau   |                     | Phyllis J. Weitzel  | / Wife  |                           | 1101                    | S. Sch                                      | numake             | er Driv                                    | e,Apt.                                  |                              |   | y,MD 21804   |
| ore                        | jes 1<br>of He<br>If iten  |                     | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re  | moval from State  | 20b. Place<br>ceme        | of Dispo<br>etery, crer | sition (Name of<br>matory or other          | of<br>er place)    |  | h 25,                                   | 20c. Locatio                 | -                                       |  |
| altimore,                  | tment of lant: If ite  |                     | 4 □ Donation 5 □ Other (Specify)  |   | Metro                     |                         | matory                                      |                    | 200  | - 1                                     | Baltim                       | ore, 1                                  | Maryland   |
| Ba                         | permit. Departr Importa any Inju   |                     | 21. Signature of Puneral Style License  |   |                           | Ba<br>49                | 5 Gov.                                      | & So<br>Ritc       | ns,P.A<br>hie Hw                           | y, Seve                                 | erna Pa                      | k Fune<br>rk, M                         | eral Home<br>21146                                 |
| Г                          |  |                     | 23a. Part . Enter the disease, or complice shock, or heart failure. List only one                       | ations that caused<br>cause on each lin                                   | the death. D              | o not ent               | er the mode o                               | of dying, suc      | ch as cardiac (                            | or respiratory a                        | arrest,                      |   | Approximate<br>Interval Between<br>Onset and Death |
| 1                          | Physician /Medicai   |                     | Immediate Cause (Final disease or condition resulting in death)   |   | non                       | Dr.                     | Tely  | 0,3                | succ                                       |   |                              |   | 8 years  |
|                            | Examiner   |                     |   | Due to (or as   | a consequence             | ce of):                 |   |                    |  |   |                              |   |  |
|                            |  | er                  | Sequentially list conditions, if any, leading to immediate  | Due to (or as   | a consequenc              | e of):                  |   |                    |  |   |                              |   |  |
|                            | cuted<br>Id<br>ansit   | Examiner            | Sequentially list conditions, if any, leading to immediate outcomes and or injury that initiated events |   |                           |                         |   |                    |  |   |                              |   |  |
| o<br>O                     | e exectan an an an an an an an an an an an an a  |                     | resulting in death) Last  | Due to (or as   | a consequent              | e of):                  |   |                    |  |   |                              |   |  |
| 8760,                      | cate be executed<br>physician and<br>the burial-transit  | dical               | ,d.   |   |                           |                         |   |                    |  |   |                              |   |  |
| Box 6                      | n certific<br>nding puse as  | n/Mec               | IF FEMALE: 23b. Was decedent pregnant 23  | c. If yes, outcome  |                           |                         | Te  |                    |  |   | 23d.                         | Date of deliv                           | /ery   |
| P.O. B                     | The law requires that the death certifii<br>tte has been signed by the attending I<br>vage 2 should be detached for use as   | Physician/Me        | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 1 □ Live birth 4 □ Pregnant at 9 □ Unknown                                |                           |                         | Ectopic pregi<br>Other (speci               |                    |  |   |                              | Month                                   | Day Year   |
|                            | quires tha<br>in signed I<br>uld be det  | ed by P             | Part II. Other significant conditions conf  | ributing to death bu  | ut not resulting          | g in the u              | nderlying caus                              | se given in f      | Part I.                                    |   | tobacco use c<br>Yes 2 □ No  |   | the cause of death? bably 4 Unknown                |
| Division or Vital Records, | he law re<br>e has bee<br>ige 2 sho  | Completed by        | MyzerTene   | in  |                           |                         |   |                    |  |   | opsy<br>ormed?               | prior to o<br>death?                    | opsy findings available ompletion of cause of      |
| ta                         | an: T<br>tifficat<br>tor, pë   | Be Co               | 25. Was case referred to medical  |   |                           |                         |   | 26.                | Place of Deat                              | 1 Yes                                   | 2 No  <br>one)               | 1 □ Yes                                 | 2□ No  |
| <u>'</u>                   | nysíci<br>nis cer<br>dírec   | To B                | examiner?<br>1 ☐ Yes 2 ☐ Ho   | ospital:<br>1 ☐ Inpatie   | nt 2 <del>⊟E</del> R/     | Outpatier               | it 3□ DOA                                   | Other:             |  | me 5□Res                                |                              | Other (Spec                             | ify)   |
| n 0                        | Attending Physician: r death. ector: After this certific by the funeral director,  |                     | 27. Manner of Death  1 → Natural 5 → Pending  | 28a. Date of Injui<br>(Month, Da)   | ry 281<br>/ <i>Year</i> ) | o. Time of<br>Injury    |   | Injury at<br>Work? |  | 28d. Describe                           | how injury oc                | curred                                  |  |
| <u>Si</u>                  | tendleath. tor: A  | catio               | 2 Accident investigation 3 Suicide 6 Could not be   | On Dines of init  | As b                      | form str                | M   | 1 ☐ Yes            |  | 00/ 1/                                  | (0,                          |   | AR CHARLE  |
| $\leq$                     | or At<br>after d<br>Direc<br>in by   | Certification:      | 4 ☐ Homicide determined   | 28e. Place of injubuilding, etc   |                           | rarm, str               | eet, ractory, o                             | пісе               |  | City or To                              | (Street and Nu<br>wn, State) | imber or Rui                            | ral Route Number,                                  |
| _                          | spital<br>ours and neral   |                     | 29a. Certifier 1 Certifying Physi   | cian: To the best of  | of my knowled             | dge, deatl              | h occurred at                               | the time, da       | ate and place,                             | and due to the                          | e cause(s) and               | manner as                               | stated.  |
|                            | To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Medical             | (Check only 2 Medical Examin  | er: On the basis of<br>and manner sta                                     | examination               | and/or in               | vestigation, in                             | my opinior         | n, death occur                             | red at the time                         | , date and pla               | ce, and due                             | to the cause(s)                                    |
|                            | To the within 3 To the comple  | ž                   | 29b. Signature and title of certifier   |   |                           |                         | 29c. L                                      | icense num         | ber  |   | 29d. Date sig                | ned (Month                              | , Day, Year)                                       |
| )                          | 1000   | N                   |   |   | >                         |                         |   | 010                | 211  | S                                       | 31-                          | 2510                                    | 8  |
|                            | a Char   |                     | 30. Name and address of person who con<br>Steven Hearn  |   |                           |                         |   | u m                | 12,218                                     | 201                                     |                              |   |  |
| *                          | Sta  |                     | 31. Date filed (Month, Day, Year)   | 32. Pgistra   | ar's Signature            | , 7                     | Hisbur                                      | ٠, .,              | 010  | 1                                       |                              |   |  |
|                            | Registi  | ar                  | MAR 2 6 20  | JO Jakob  | wo                        | 4                       | MAN W                                       |                    |  |   |                              |   |  |

DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3/20/2008 Physician 8:30pm Margaret Ledig Wallace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Spa Creek Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/18/1924 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M % TXF 84 MD 216-36-8242 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 27 and any injury or other trainment 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Anne Arundel Annapolis 1 ☐ Yes XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 934 Bay Ridge Ave. Apt 304 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White þ Specify: 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Co-Founder Maritime Museum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Ledig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chris Coile 2727 Coconut Dr., Sanibel, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 03/22/2008 Baltimore, MD 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Ligensee 12 Ridgely Ave. Annapolis, MD 21401 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** (anuv ( ~ ~ /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Yes 2 PNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

On the 2/1/P D. Donn Druc

and manner stated.

MAR 26 2008



the

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29c. License number

29d. Date signed (Month, Day, Year)

3/21/1896

Ch. H. MA 21619

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1771 Daisey Ct. Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 216-22-3044 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Year) Days Hours 1 □ M 2**X** F Months 1/8/1929 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Millersville Anne Arundel 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1771 Daisey Ct. 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ÆNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ★ No Specify: White ģ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Greenwell Clara Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, MD 21108 Son 1771 Daisev CT. Tod Wagner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 3/27/2008 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 21. Sign it re of Funeral Ser 22. Name and Address of Facility Hardesty Funeral Home, P.A. ice Licensee 12 Ridgely Ave. Annapolis, MD 21401 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Enter the d Approximate Interval Between Onset and Death ck, or heart fail ete Cause (Fi or condition g in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

**Examiner** or Attending Physician; The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, Medical Certification: To this After t within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital

**Funeral** 

Director

28a-f show

ō

items 23a

"natural", or

other than

Department of Health and Mental Important: If item 27 Is marked o

**Physician** /Medical

Injury

Examiner must be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

1 Natural 2 □ Accident 3 ☐ Suicide 4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 🛰 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

23a) (Type, Print)

State Registrar

MAR 2 6 2008

The law requires that the death certificate be executed as the burial-transit and Division of Vital Records, P.O. Box 68760, the attending physician hes certificete Hospital or Attending Physician: death. neral Director: A

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumatic event, the Medical Examine.

Physician /Medical Examiner

> Physician/Medicai Examiner ģ Completed Be ( Certification: To

29a. Certifier (Check only

to the cause (s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

State

Medical

31. Date filed

of death (Item 23a) (Type, Print)

Thus Samuel Chan, M/D 32 Registrar's Signature

Registrar

within 24 hours a

2

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 1 | $\cap$ |   | 0 | * 1 | 1 | 8 | 1 |
|---|--------|---|---|-----|---|---|---|
| 2 | U      | U | 0 | 1   | į | 0 | I |

|   | 1-<br>Re                           | For State eqistrar Amend#8 P   | erFHPGC3-                           | 26-08Cer  | tificate c                 | f Death  |                     |                                   | 12   | Date of Dea                               | Reg. No.   |   | 3.                       | . Time of Death   |
|---|------------------------------------|--|-------------------------------------|---|----------------------------|--|---------------------|-----------------------------------|--|---|--|---|--------------------------|---|
| Physiciar<br>Examin   | n/<br>ier                          | Marcus A Wil   | liams                               |   |                            |  |                     |                                   |  | Month<br>March 19                         | Day<br>2008  | Year  |                          | 1919 hrs  |
|   | 4                                  | a. Facility Name (if not institution Prince George's Hosp  |                                     | umber)  |                            | 4b. City, To<br>Cheve  |                     | ocation of                        |  |   | Prince George's  f Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign |   |                          |   |
| Funeral<br>Director   | 1                                  | 5. Social Security Number  | 6. Sex                              | 7. Age (In yrs. la  |                            | If Under   | _                   | If Under<br>Hours                 | Min.   | 8. Date of B December 2008                | ber 4  | 4,  | Coun                     | place (State of Foreign latry)  in ington DC                      |
| ow any  | o Be Completed by Funeral Director | Maryland Prince George's Dist  10e. Street and Number  7417 Marlborough Pike  11. Marital Status  1 XXNever Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  Ninth  None  17. Father's Name (First, Middle, Last)  Samuel Smith  19a. Informant's Name/Relationship (Type, Print) |                                     |   |                            | If Yes, specify Cuban, Mexican, Puerto Roll  1 Yes 2 X No specify:  16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire  Student  18.Mother's Name ( Lukiett  19b. Mailing Address (Street and Number or Roll |                     |                                   | cify Yes or Noticen, etc.)  ork done ed)  (First, Middle ta W11  tural Route Note Note 1 | 10g. Citi Uni No- 16b. F H e, Maidet 11am | 14. Race Whit Specify: Kind of Birlingh In Surnamens                 | shman h School name) r Town, State, Zip Code) |                          |   |
| Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and I Important: If item 27 is rightry or other traumatic   | 1                                  | Samuel Smith/  20a. Method of Disposition  1 K Burial 2 Cremati  4 Tonation 5 Other  21. Sig tur of Funeral rvi  |                                     |   |                            |  |                     | on DC al Home Inc                 |  |   |  |   |                          |   |
| hysician<br>اedical<br>دaminer.   | h ()                               | failure. List only one cau  Immediate Cause (Final disea or condition resulting in death  Sequentially list conditions, if any, leading to immediate   | ase a Gunshot  Due to (or a         | Wound of To   | orso<br>of):               |  |                     |                                   |  |   |  |   |                          | Death   |
| ecuted<br>and<br>- transit  | I Examiner                         | (Disease or injury that initiate events resulting in death) La   | d Contactor                         | as a consequence  | e of):                     |  |                     |                                   |  |   |  |   |                          |   |
| 760,<br>cate be ex<br>physician   | Medic                              | 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy   |                                     |   |                            |  |                     |                                   |  | Day Year                                  |  |   |                          |   |
| ires that the degrifted by the standard by the standard by the standard for   | by Ph                              |  |                                     |   | ot resulting in            | the underlyi   | ng cause            | e given in                        | Part I.  | . 1                                       | Yes  | 2 🗸 No  | 3 Pr                     | o the cause of death? obably 4 Unknown autopsy findings available |
| of Vital Records, ng Physician: The law require the tris certificate has been suneral director, page 2 should 1   | poleto                             |  |                                     |   |                            |  |                     |                                   |  |   | Was an<br>autopsy<br>performe<br>Yes 2                               | ed?   | prior to<br>death?       | completion of cause of  |
| ital Recsician: The list certificate lirector, page   | Be Co                              | examiner?  | Hospital:                           | ✓ Inpatient 2   | ER/Outp                    | atient 3   | 26.Pla              | Other                             |  | k only one)<br>sing Home                  |  | esidence                                      |                          | ner:  |
| Sion<br>Attendia<br>r death.<br>ector: /  | oy une                             | 27 Manner of Death   | Pending Investigation Could not be  | Date of Injury<br>Month, Day, Year)<br>JND:<br>19, 2008<br>Place of Injury - A<br>ecify) Single F | 28b. Tir<br>FOUN<br>1721 h | irs  | 1                   | njury at W<br>Yes 2<br>e building | <b>✓</b> No  | Subject<br>28f. Loca                      | t shot   |   | umber or                 | Rural Route Number, Ci  |
| Divi  To the Hospital or within 24 hours after To the Funeral Directornal Pileston Commission of the Funeral Directornal Pileston of the Funeral Directornal Police of the Funeral Directornal Police of the Police |                                    |  | ng Physician: To th                 | e best of my know   |                            | occurred at<br>estigation, ir  | the time<br>my opin | , date and<br>iion, death         | place, a   | nd due to the                             | e cause(<br>e, date an   | s) and ma                                     | inner as s<br>and due to | tated.<br>the cause(s)  |
| To the within 2   | Modical                            | 29b. Signature and title of c  | and mai                             | ner stated.   |                            |  | 29c. Lic            | ense numl                         |  |   | 1  | 29d. Date<br>March                            | signed (                 | Month, Day, Year)   |
| Q_3   |                                    | 30. Name and address of po   | erson who complete<br>Assistant Med | d cause of death (  | (Item 23a)<br>111 P        | enn Stree  | t, Balti            | more, N                           | иD 212   | 201                                       |  |   |                          |   |
|   | Stat                               |  |                                     | 32. Registrar's Sig   | _                          | 20   |                     |                                   |  |   |  |   |                          |   |

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day LOUIS WILES 19, 2008 1732 M MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY GAITHERSBURG SHADY GROVE ADVENTIST HOSPITAL 8. Date of Birth (Month, Day, if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign LIBERTA 1958 417-04-7347 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MONTGOMERY ROCKVILLE MD 10g. Citizen of What Country? LIBERIA 10e. Street and Number 10f. Zip Code 20850 455 ELM CROFT BLVD #7101 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2☐No Specify. 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAE DENNIS LOUIS A. WILES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 ELM CROFT BLVD #7101 ROCKVILLE, MD. 20850 BRENDA WILES/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 □Removal from State BELTSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 3/22/08 21. Signatur of Funeral Service License 22. Name and Address of Facility CAPITOL MORTUARY INC. 1425 MARYLAND AVE., N.E. WASHINGTON, D.C. 20002 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **OBSTRUCTED** TRACHEOSTOMY Due to (or as a consequence of) CARDIOPULMONARY ARREST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed? /es 2X No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 XER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Naturai

1 ☐ Yes 2 ☐ No

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3/20/08

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

certificate be executed

P.O. Box 68760,

Division or Vital Records,

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

ျ

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

marked other - snould be filt lith and Mental Hv 7 is mark

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any Injury or other traumatic events.

death

72 hours after

Baltimore, Maryland 21215-0036

Examine burial-transit the as page 2

and physician Physician/Medical attending | ed by the detached signed to þ Completed been has certificate Be P this after death.

I Director: After the in by the funeral Certification:

Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral I 1, Registrar

filled

Medical

TIR 31. Date filed (Month, Day, Year) State 2008 MAR 2 6

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

9501 Mb 32. Registrar's Signature

and manner stated.

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** VIOLA L. ADAMS 8, 2008 1:28 April Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) 01/06/1941 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F MARYLAND 213-74-8105 67 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County Items 23a or 28a-f show ner must be notifled at 1 ☐ Yes 2 No Director MD BALTIMORE FREELAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1826 FREELAND 21053 USA Completed by Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Item Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOMEMAKER ages 1 and 2 should be filed wi ent of Health and Mental Hygien it: If item 27 is marked other th y or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ALBERT D. MIDWIG GRETA CROUSE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY CATALDI (FRIEND) 21133 RIDGE RD. FREELAND, MD. 21053. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY 04/09/08 BALTO CITY, MD. Department Important: I any Injury o 21. Signature of Eupyral Service Licer HENRY 16924 W. JENKINS & SONS C YORK RD MONKTON, MD. de 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): TRUCTIVE PULMONARY DIJENSE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed sician and burial-tran Due to (or as a consequence of): physician a sthe burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗝 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has performed? certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Leath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the the

Adoms

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

22. Registrar's Signature

29c. License number

NUTSCHWESST, STESOO DUSPOR

29d. Date signed (Month, Day, Year)

| 08-02671   |  |                  | Please Type   |   |                            |              |                            |                                |  |                                  |  |
|--|--|------------------|---|---|----------------------------|--------------|----------------------------|--------------------------------|--|----------------------------------|--|
| Joseph John  | AKC  | 1<br>F           | - For State<br>Legistrar  | e of Maryland                               | Certifica                  |              |                            | d Menta                        | Re   | g. No.                           | 008   181  |
| Phys<br>Medical Exa  |  | 11/              | 1. Decedent's Name (First, Middle,La                                    |   | nski Jr                    | •            |                            |                                | 2. Date of Death<br>Month<br>April 5, 200    | Day Year                         | 3. Time of Death<br>0915 hrs                       |
| Wiedical Exa   |  |                  | Joseph Jo  4a. Facility Name (if not institution, g  Nabbs Creek Marina |   |                            | 4b           | . City, Town, or           |                                |  | 4c. County of E                  |  |
| -  |  | 4                |   | Sex 7. Ag                                   | e (In yrs. last birt       |              | If Under 1 Yea             |                                | 4Hrs. 8. Date of Birt                        |                                  | J. Birthplace (State or                            |
| Funer<br>Direct  |  | -                |   | Хм 2 F                                      | 58                         | Yrs.         | Months Day                 |                                | Min. Jan. 1                                  | 1, 1950 F                        | oreign<br>Country) MD                              |
|  |  | Ŀ                | Usual Residence of Decedent   |   |                            |              |                            |                                |  |                                  | 10d. Inside City Limits                            |
| w any  |  | 1                | 10a. State 10b. County  MD Anne Au                                      | J o T                                       | 10c. City, Town            |              |                            |                                |  |                                  | 1 Yes 2 X No                                       |
| ryland a-f she   | t once   | 향                | MD Anne Au  10e. Street and Number                                      | uder  | Glen                       |              | 10f. Zip Code              |                                | 10   | g. Citizen of What               | Country?   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marelal Hygiene. Innovation: If item 7: is marked other than "natural", or items 23a or 28a-f she  | notified at once.  | Funeral Director | 7678 Mueller Dr   | ive   |                            |              | 2106                       | 0                              |  | U.S.A.                           |  |
| h with   | pe no  | eral             | 11. Marital Status  | 12. Was Deceden                             |                            | 13. Was      | Decedent of Hi             | spanic Origin<br>n, Mexican, P | ? ( Specify Yes or No-<br>uerto Rican, etc.) | 14. Race - A<br>White, e         | American Indian, Black,<br>etc.                    |
| or teat  | must   |                  | 1 Never Married 2 Marrie 3 Widowed 4 XDivorce                           | 1 X Yes 2<br>ed If Yes, Give Year           | No                         |              | es 2 X No                  |                                |  | Specify:                         | White  |
| urs after  | amine  | a<br>P           | 15. Decedent's Education (Specify                                       | or Dates:                                   | npleted) 16a.              | Decedent's   | Usual Occupa               | ation (Give kin                | d of work done                               | 16b. Kind of Busin               | ness/Industry                                      |
| 6<br>72 ho   | cul Ex   | Completed        | Elementary/Secondary (0-12)   | College (1-4 or                             | 5+)                        |              | st of working life         |                                | e retired)                                   | Constru                          | ation  |
| 003<br>within<br>giene.  | Medi   | ğ,               | 12<br>17. Father's Name (First, Middle, La                              | et)   | 56                         | ETI FI       | mployed                    |                                | Name (First, Middle, N                       |                                  | etton  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than   | nt, the  | BeC              | Joseph Akczinsk   | •   |                            |              |                            |                                | a Barbara                                    |                                  |  |
| 21;<br>nould b   | tic eve  |                  | 19a. informant's Name/Relationship                                      |   |                            |              |                            |                                | er or Rural Route Num<br>Glen Burr           |                                  |  |
| MD and 2 sho calth and 2 is  | rauma  |                  | Miss Terry Ann G  | ull/Sister                                  |                            |              | on (Name of o              |                                |  |                                  | ity or Town, State                                 |
| lore   | ther   |                  | 1 X Burial 2 Cremation  |   | late                       | tory or othe | n Mem.                     |                                | April 11,<br>2008                            | Glen B                           | urnie, MD  |
| Baltimore,<br>permit Pages I as<br>Department of He.   | ry or  | H                | 4 Donation 5 Other Spec<br>21. Signature of Funeral Service Lic         |   | Gren                       |              |                            |                                |  |                                  | & Cremation  |
| <b>В</b>   |  |                  | Mark Re Vary  | ire   | MO135                      | 7 Se         | rvices                     | 1 2nd                          | Avenue SW                                    | Glen Bur                         | nie, MD 21061                                      |
| Physici<br>/Medic  |  |                  | 23a. Fert I. Er ter the disease, or confailure. List only one cause on  | each line.                                  | d the death. Do n          | ot enter the | e mode of dying            | g, such as car                 | diac or respiratory arr                      | est, shock, or nean              | Approximate Interval<br>Between Onset and<br>Death |
| c 'xamir   | _  | П                | Immediate Cause (Final disease or condition resulting in death)         | a. Drowning  Due to (or as a cons           | sequence of):              |              |                            |                                |  |                                  |  |
|  |  |                  | Sequentially list conditions,   | b   |                            |              |                            |                                |  |                                  |  |
|  |  | xaminer          | if any, leading to immediate cause. Enter Underlying Cause              | Due to (or as a cons<br>c.                  | sequence of):              |              |                            |                                |  |                                  |  |
| P  | ısıt   | Exar             | (Disease or injury that initiated events resulting in death) Last       | Due to (or as a cons                        | sequence of):              |              |                            |                                |  |                                  |  |
| execut   | al - tran  | ical E           | X UNPENDED  | d. X AMENDED 27.                            | 000 6                      |              | 070 5/0                    |                                |  |                                  |  |
| .60,<br>ate be   | te buri  | Medi             | IF FEMALE:  | #1,23a,27,<br>23c. If yes, outco            | . &28a-f p                 |              | <u>g8/9 5/2</u>            |                                |  | 23d. Date of d                   |  |
| 687<br>certific  | se as t  | ian/             | 23b. Was decedent pregnant in the past 12 months?                       | 1 Live birth 4 Pregnant a                   | A Charles and all a makes  | - =          | al death 3<br>er (Specify) | Ectopic p                      | pregnancy                                    | Month                            | Day Year   |
| Box 68760,<br>e death certificate b  | d for u  | Physician/M      | 1 Yes 2 No 9 Unkno  | wn g Unknown                                |                            |              |                            |                                |  |                                  |  |
| P.O.   | detach   | by P             | Part II. Other significant condition                                    | s contributing to dea                       | th but not resulting       | ng in the ur | nderlying cause            | e given in Part                |  | obacco use contrib<br>s 2 ✔ No 3 | ute to the cause of death?  Probably 4 Unknown     |
| IS, F  | ald be   |                  |   |   | <del></del> _              |              |                            |                                | 24a. Was                                     | an   24b. W                      | ere autopsy findings available                     |
| SOFC<br>law re   | 2 sho  | ompleted         |   |   |                            |              |                            | -                              |  | ormed? de                        | ior to completion of cause of eath?                |
| Re.  | r, page  | ပ                | 25. Was case referred to medical  | <del></del>                                 |                            |              | 26.Pla                     | ce of Death (C                 | Theck only one)                              | 2 No 1                           | Yes 2 No   |
| of Vital Records,  B. Physician: The law required on the law requi | directo  | o Be             | examiner?  1  Yes 2 No  | Hospital: 1 Inpat                           | ient 2 ER/0                | Outpatient   |                            | Other                          | Nursing Home 5                               | Residence 6                      | Other: Scene                                       |
| ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death.  About this confidence has been alread by the attending physician and  | After this certificate has occar signed by the attending purysician and funeral director, page 2 should be detached for use as the burial - tran | -                | 27. Manner of Death   | 28a. Date of In<br>(Month, Day              | jury 28b<br>Year)          | . Time of In | ′′                         | jury at Work?                  |  | how injury occurre               |  |
| Sion<br>(ttendi  | y the f  | atio             | 1 Natural 5 Pendin<br>2 X Accident Investig                             | Fnd 4/5                                     | /2008 FN                   | d 8:16       | am                         | Yes 2 X                        | J  | fell off bo                      | oat<br>r or Rural Route Number, City               |
| Division tal or Attendir   | ed in b  | Certification:   | 3 Suicide 6 Could r   | not be                                      | Injury - At home,<br>arina | ıarmı, stree | i, iactory, office         | s punung, etc.                 |  | State GLen Bur                   |  |
| Division To the Hospital or Attendir   | tely fill  |                  | 4 Homicide  29a. Certifier 1 Certifying Physical Check only             | sician: To the best of                      | mv knowledge, d            | eath occurr  | ed at the time,            | date and plac                  | ce, and due to the cau                       | se(s) and manner                 | as stated.   |
| [o the]  | complet  | Medical          | one) 2 Medical Exami  | ner:On the basis of ex<br>and manner stated | amination and/or           | investigati  | on, in my opini            | on, death occ                  | urred at the time, date                      | and place, and du                | ue to the cause(s)                                 |
|  | \ \  | ž                | 29b. Signature and title of certifier                                   |   |                            |              | 29c. Lice                  | nse number                     |  | 29d. Date signe                  | d (Month, Day, Year)                               |

State

Winjonte

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registrar

April 6, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|  |  |                   | 1 - For<br>State<br>Registrar  | Otate of W  | ar yran a                       | •                         |                         |                             | Death                              | A110 11                 |                                      | Reg. N  | 4 U U                              | Ö                                       |                   | 81                 |
|--|--|-------------------|--|---|---------------------------------|---------------------------|-------------------------|-----------------------------|------------------------------------|-------------------------|--------------------------------------|---|------------------------------------|---|-------------------|--------------------|
| Е  | Dharaisi   |                   | 1. Decedent's Name (First, Middle  | , Last)   |                                 |                           |                         |                             |                                    |                         | 2. Date of De                        |   | ay Year                            |   | me of [           | eath               |
|  | Physicia<br>/Medic   |                   | Richard Kenda  | 11 Allen  |                                 |                           |                         |                             |                                    |                         | April                                |   | 2008                               |   | 05                | Рм                 |
|  | Examin   |                   | 4a. Facility Name (If not institution  | , give street and number  | )                               |                           | 4b. City                | , Town, or                  | Location o                         | of Death                | -                                    | 4c. County of Death   |                                    |   |                   |                    |
| -  |  |                   | Fox Chase Rehabilit  |   | ing Cent                        | er                        |                         |                             | Spri                               |                         |                                      | Montgomery  |                                    |   |                   |                    |
|  | Funeral<br>Director  |                   | 5. Social Security Number 138-32-0192  | 6. Sex 7. Ag  | ge (In yrs. lasi<br>66          | t birthday)<br>Yrs.       | If Unde<br>Months       | Days                        | If Under 2<br>Hours                | 24 Hrs.<br>Min.         | 8. Date of Bi<br>(Month, D<br>July 9 | rth<br>ay, Yea<br>1   | 9. B<br>941 Ne                     | irthplace (S<br>So <i>untry)</i><br>Jer |                   | Foreign            |
|  | and w  |                   | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, T                    | Town or Lo                | cation                  |                             |                                    |                         |                                      |   |                                    | 10d. Ins                                | ide City          | / Limits           |
|  | laryla<br>sho  | ō                 | ,  | D 1   |                                 |                           |                         |                             |                                    |                         |                                      |   |                                    |   | Yes :             |                    |
|  | 28a-1  | Director          | Florida Miami  10e. Street and Number  | -Dade   | Cor                             | cal G                     |                         | p Code                      |                                    |                         |                                      | 100.0   | Citizen of What C                  | Country?                                |                   |                    |
| with t   | with a or  |                   |  |   |                                 |                           |                         |                             | _                                  |                         |                                      | 3   | United States                      |   |                   |                    |
|  | eath   | era               | 4600 Santa Ma 11. Marital Status   | 12. Was Decedent  | EverinIIS                       | 13 1                      |                         | 33146                       |                                    | ain? (Sne               | ecify Yes or N                       |   | 14. Race - An                      |   |                   |                    |
| 5-UU36<br>72 hours after death with the Maryland | be filed within 72 hours after death with the Marylan ital Hygiene. id other than "natural", or items 23a or 28a-f show event, it a Medical Expolition and the modified at | by Funeral        | 1 X Never Married 2 Marri<br>3 Widowed 4 Divorced  | Armed Forces  | ?<br>No                         |                           |                         |                             | Specify:                           | i, Puerto               | ecify Yes or N<br>Rican, etc.)       |   | Black, Wh                          | ite, etc.                               | ari,              |                    |
| 2-00 <i>2</i>                                    | 2 hou  |                   | 15. Decedent   | 's Education  |                                 | l 6a. Dece                | dent's Us               | ual Occup                   | ation                              |                         |                                      | 16b.  | I<br>Kind of Busines               | s/Industry                              |                   |                    |
| N  | e.<br>F. nin 7;  | Completed         | (Specify only highes Elementary/Secondary (0-12)   | College (1-4or  | 5+)                             | (Give<br>life. i          | kind of w<br>DO NOT i   | ork done d<br>use retired   | during most<br>()                  | t of worki              | ng                                   | 1   |                                    |   |                   |                    |
| 7  | e filed within 7<br>al Hygiene.<br>I other than "r<br>vent, II a Med   | ĕ                 | Ziomoniary/ossendary (o 12)  | 4+  |                                 |                           | Of                      | fice                        | r                                  |                         |                                      | Uni   | ted Sta                            | tes N                                   | avy               |                    |
| and  | al Hy<br>lothe   | Be                | 17. Father's Name (First, Middle, I  | Last)   |                                 |                           |                         |                             | 18. Mothe                          | er's Name               | (First, Middle                       | ə, Maide  | en Surname)                        |   |                   |                    |
| <u>a</u>   | 2 should be f<br>and Mental I<br>is marked of<br>raumatic eve  | ၉                 | Warren Herber  | t Allen   |                                 |                           |                         |                             | Eli:                               | zabe                    | th Ann                               | Ken   | dall                               |   |                   |                    |
| Mar  | 2 sho<br>and<br>is ma  |                   | 19a. Informant's Name/Relationsh   | ng Addres   | s (Street                       | and Numbe                 | er or Rura              | al Route Numi               | ber, City                          | or Town, State          | , Zip Code)                          | 1   |                                    |   |                   |                    |
| -  | and 2<br>lealth<br>m 27<br>her tra   |                   | Susan George /   | Sister  | 4                               | 4600                      | Sant                    | a Mar                       | cia St                             | treet                   | t, Cora                              | 11 G  | ables,                             | FL 33                                   | 146               |                    |
| e<br>C   | es 1<br>of He<br>fiten   |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation  | 2 Domewal from Chate  | 20b. Plac<br>cem                | e of Dispo<br>etery, crer | sition (Na<br>natory or | ime of<br>other plac        | e) A                               | pri1                    | Pate<br>7                            | 20c.  | Location - City of                 | r Town, St                              | ate               |                    |
| ащшог  | Pages<br>ment of I<br>ant: If ite<br>ury or o  |                   | 4 □ Donation 5 □ Other (S <sub>p</sub>   |   | Montgo                          | omery                     | Crema                   | torium                      | ı — !                              | 2                       | 008                                  | Bet   | hesda,                             | Mary1                                   | and               |                    |
| Dall   | permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.   |                   | 21. Signature of Funeral Service I   | Licensee  | MO147                           | 3 Be                      | Name a<br>thes<br>thes  | nd Addres<br>da-Cl<br>da. N | ss of Facility<br>nevy (<br>Marv1a | yRobe<br>Chase<br>and   | ert A.<br>e, Inc.<br>20814-3         | Pum<br>7<br>3501  | phrey F<br>557 Wis                 | unera<br>consi                          | 1 He<br>n A       | ome/<br>venue      |
|  |  |                   | 23a. Part 1. Enter the disease, or shock, or heart failure. List   | complications that cause  | d the death.                    |                           |                         |                             |                                    |                         |                                      |   |                                    | Appro                                   | ximate<br>al Betw | een                |
| 1  | Physician<br>/Medical  |                   | Immediate Cause (Final disease or condition resulting in death)  | _a. Adenoca   |                                 |                           | Duod                    | enum                        | - Me                               | tast                    | atic                                 |   |                                    | Onse                                    | and De            | eath               |
|  | Examiner   |                   |  | Due to (or as   | s a consequen                   | ice oi):                  |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
|  |  | ē                 | Sequentially list conditions,  | b. Due to (or as  | a consequen                     | nne offi                  |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
| ١.   | d<br>d<br>ansit  | Examiner          | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   |   |                                 |                           |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
| ,<br>V   | exec<br>an an<br>riaf-tr   |                   | resulting in death) Last   | Due to (or as   | a consequen                     | ice of):                  |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
| ,00/00   | icate be executed<br>physician and<br>the burial-transit   | cal               | -  | d   |                                 |                           |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
| 0  | rtificate be executed<br>ng physician and<br>s as the burial-transit   | Medical           |  | 1   |                                 |                           |                         |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
| O. DOX   | law requires that the death cer<br>as been signed by the attendir<br>2 should be detached for use  | Physician/N       | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  | 23c. If yes, outcome 1  Live birth 4  Pregnant                    | 2 Fetal de                      | ath 3[                    | ☐ Ectopic<br>☐ Other (s | pregnancy                   | у                                  |                         |                                      |   | 23d. Date of d<br>Month            | elivery<br>Day                          | Ye                | ear                |
| Ţ.   | at the   | Phy               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to |   |                                 |                           |                         |                             |                                    |                         |                                      |   | - 4h-O                             |   |                   |                    |
| Records,   | equires then signed  | þ                 | Hypertension   | _   | but not resultir                | ng in the ui              | nderlying               | cause give                  | en in Part I.                      |                         |                                      |   | 2 No 3                             |   |                   |                    |
| ပ်   | 2 2 2  | Completed         |  |   |                                 |                           |                         |                             |                                    |                         | 24a. Was                             |   | 24b. Were                          | autopsy fin                             | dings a           | vailable<br>use of |
| ב  | The  | 70T               |  |   |                                 |                           |                         |                             |                                    |                         | perf<br>1 □ Yes                      | ormed?  | death'                             | ?                                       |                   |                    |
| N I G  | sian:<br>ertific<br>ctor,  | Be (              | 25. Was case referred to medical examiner?   |   |                                 |                           |                         |                             | 26. Place                          | of Death                | (Check only                          | one)  |                                    |   |                   |                    |
| 5  | hysic<br>his ce<br>I dire  |                   | 1 Yes 2 No   | Hospital: 1 ☐ Inpati  | ient 2□ER                       | l/Outpatier               | nt 3 🗆 🗅                | OA Othe                     | er: 4 <b>3</b> Nu                  | rsing Ho                | me 5 ☐ Res                           | sidence   | 6 ☐ Other (Sp                      | ecify)                                  |                   |                    |
| VISION   | Attending Physician: The lav<br>r death.<br>ector: After this certificate has<br>by the funeral director, page 2 '   | ation:            | 27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investig   | ation   | ury<br>ay, Year)                | Bb. Time of<br>Injury     | f<br>M                  | 28c. Injur<br>Work<br>1 □   | yat<br><br Yes 2∐1                 |                         | 28d. Describe                        | how inj   | ury occurred                       |   |                   |                    |
|  | To the Hospital or Attendi<br>within 24 hours after death. To the Funeral Director: A<br>completely filled in by the fu  | Certification: To | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi  | ned   28e. Place of in  | jury - At home<br>tc. (Specify) | e, farm, str              | eet, facto              | ry, office                  |                                    |                         | 28f. Location<br>City or To          | n (Street and Number or Rural Route Number,<br>Town, State) |                                    |   |                   |                    |
|  | ne Hospi.<br>n 24 hour<br>ne Funera  | Medical (         | 29a. Certifier 1 ☑ Certifyin (Check only one) 1 ☑ Medical I  | g Physician: To the best<br>Examiner: On the basis<br>and manners | of examination                  | edge, deat<br>n and/or in | h occurre<br>vestigatio | d at the tir<br>n, in my o  | ne, date an<br>pinion, dea         | nd place,<br>ath occurr | and due to the<br>red at the time    | e cause<br>e, date a  | (s) and manner<br>and place, and d | as stated.<br>ue to the ca              | ause(s)           |                    |
|  | To th<br>Withi   | M                 | 29b. Signature and title of certifier  |   |                                 |                           | 29                      | c. Licens                   | e number                           |                         |                                      | 29d. [  | Date signed (Mo.                   | nth, Day, Y                             | ear)              |                    |
|  |  |                   | Three  |   |                                 |                           |                         | D286                        | 556                                |                         |                                      | Apr   | i1 7, 2                            | 800                                     |                   |                    |
|  | الدي   |                   | 30. Name and address of person v   | who completed cause of  | death (Item 23                  | 3a) (Type,                | Print)                  |                             |                                    |                         |                                      |   |                                    |   |                   |                    |
|  | 1541   |                   | Ravi Passi, M.D  |   | ady Gr                          | oveR                      | load,                   | Ste                         | 208                                | , Ro                    | ckville                              | e, M  | aryland                            | 2085                                    | 00                |                    |
|  | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year) APR 1 1  | 2. Regist   | rar's Signature                 | Ano                       | de                      |                             |                                    |                         |                                      |   |                                    |   |                   |                    |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4, 2008 9:16PM <u>April</u> Robert Hamilton Anthony /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8714 Rayburn Road Montgomery Bethesda 6. Sex 1 ★ M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 029-10-6910 97 Yrs November 4, 1910 Director Massachusetts Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any Injury or other traumating. 20817 United States 8714 Rayburn Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Investigator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Hamilton မ Andrew Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8714 Rayburn Road Bethesda, Maryland 20817 Brooke F. Anthony/ Daughter 20b. Place of Disposition (Name of Montgomery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Montgomery or other place)
Crematorium, Inc.

22. Name and Address of Facility Robert A. Pump rey Funeral Rome/
Hethesda-Chevy Chase, Inc. 755/Wisconsin Avenue

M00335 Bethesda, Maryland 20814-3501 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia Month resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) ⊒Yes 2□No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Renal Insufficany 24a. Was an page 2 s autopsy performed? 1 □ Yes 2 X No 1 ☐Yes 2 ☐ No Alzheimer's Disease 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

death certificate be executed and I-trar Box 68760 the attending physician hed for use as the buria signed by the ad be detached to P.0. Records, has certificate Division of Vital Physician: this filled in by the funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After

the Maryland

completely within 2 To the I

١3

Medical

State Registrar

Damien Doyle, M.D.31. Date filed (Month, Day, Year) APR 1 1 2

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1801

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

East Jefferson Street, Rockville, Maryland 20852-4048

1X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

737756VE

29d. Date signed (Month, Day, Year)

April 6, 2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                     | For  State Registrar  | State of                          | of Marylan                          |                              | artment of F                             |                            | and Mental H                                    | ygiene (                      | 008  | 1 8 7  |  |
|----------------------------|--|---------------------|---|-----------------------------------|-------------------------------------|------------------------------|--|----------------------------|---|-------------------------------|--|--|--|
| Π                          | *  | Ser                 | Decedent's Name (First, Middle,   | Last)                             |                                     |                              |  |                            | 2. Date of E                                    | eath                          | .,   | 3. Time of Death                                 |  |
|                            | Physici<br>/Medic  |                     | Annette Bulling   | ger                               |                                     |                              |  |                            | April   | 8, <sup>Day</sup> 20          | 08 Year  | 9:35 PM  |  |
|                            | Examin   |                     | 4a. Facility Name (If not institution,  | give street and nu                | ımber)                              |                              | 4b. City, Town, o                        | Location of                | of Death  | 4c. County of Death           |  |  |  |
| *                          |  |                     | Franklin Woods N  |                                   |                                     |                              | Rossvi                                   |                            |   |                               | Baltimore  |  |  |
| ŀ                          | Funeral  | 1                   | · ·   | Sex<br>1 M 2 F                    | 7. Age (In yrs.                     | **                           | If Under 1 Year<br>Months Days           | If Under<br>Hours          | Min. (Month, L                                  | irth<br>ay, Year)             | Cour   |  |  |
| £ *                        | Director   |                     | 219–32–6240 Usual Residence of Decedent   |                                   | 71                                  | 115.                         |  |                            | 05/15   | /1936                         | Kent   | ucky   |  |
|                            | yland<br>10W   |                     | 10a. State 10b. County  |                                   | 10c. Cit                            | y, Town or Lo                | cation                                   |                            |   |                               | 1  | 0d. Inside City Limits                           |  |
|                            | Man<br>a-1 eh  | tor                 | Maryland Baltimo  | ore                               | Mic                                 | dle Ri                       | ver                                      |                            |   |                               |  | 1 ☐ Yes 🏋 No                                     |  |
|                            | or 28,   | lrec                | 10e. Street and Number  |                                   |                                     |                              | 10f. Zip Code                            |                            |   | 10g. Citize                   | n of What Cour   | ntry?  |  |
|                            | 23a (  | ral                 | 1320 Windlass Di  | rive                              |                                     |                              | 21220                                    |                            |   | U.S.                          |  |  |  |
|                            | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Iteme 23e or 28e-f ehow<br>he Madical Examiner must be notified at   | by Funeral Director | 11. Marital Status  | Armed F                           |                                     | .S. 13. \                    | Was Decedent of H<br>f Yes, specify Cuba | ispanic Ori<br>an, Mexicar | gin? (Specify Yes or N<br>, Puerto Rican, etc.) | 10-                           | <ul> <li>Race - Americ</li> <li>Black, White,</li> </ul> |  |  |
| 36                         | s afte   | y Fi                | 1 ☐ Never Married 2 ☐ Marner 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes<br>If Yes, G<br>Year or I | 2 🔀 No<br>ive                       |                              | 1 ☐ Yes 2X No                            | Specify:                   |   | Sı                            | pecify: Wh   | ite  |  |
| 8                          | hour   | ed                  | 15. Decedent's  |                                   | Jales.                              | 16a. Dece                    | dent's Usual Occup                       | ation                      |   | 16b. Kind                     | of Business/In   |  |  |
| Maryland 21215-0036        | n "na  | Completed           | (Specify only highest<br>Elementary/Secondary (0-12)  | grade completed,                  |                                     | (Give                        | kind of work done<br>DO NOT use retired  | during mos                 | t of working                                    |                               |  | ,  |  |
| 212                        | d with   | mo;                 | 12  | College                           | (1-4or 5+)                          | Homem                        | aker                                     |                            |   | Own :                         | Home   |  |  |
| 9                          | e file<br>al Hys<br>oth  | Bec                 | 17. Father's Name (First, Middle, La  | ist)                              |                                     |                              |  | 18. Mothe                  | er's Name (First, Midd                          | le, Maiden Su                 | ımame)   |  |  |
| <u>a</u>                   | Menta<br>Menta<br>arked  | To                  | Charles Guy   |                                   |                                     |                              |  | Edit                       | n Hale  |                               |  |  |  |
| a                          | 2 sho<br>and<br>is mu  |                     | 19a. Informant's Name/Relationship  | (Type, Print)                     |                                     | 19b. Mailir                  | ng Address (Street                       | and Numbe                  | ar or Rural Route Num                           | ber, City or T                | own, State, Zip  | Code)  |  |
| 2                          | and<br>leafth<br>m 27  |                     | Lou Cioffioni (S  | Son)                              | 204 5                               | 6523                         | Hilltop i                                | venu                       | Baltimo   | ce, Ma                        | ryland   | 21206  |  |
| Baltimore,                 | ges 1<br>t of H<br>If its<br>or ot   |                     | 20a. Method of Disposition  1XXSurial 2 ☐ Cremation 3   | Removal from                      | Ctato                               | cemetery, crer               | natory`or other plac                     |                            |   |                               | ition - City or To                                       |  |  |
| Ē                          | t. Pa<br>ntmen<br>ntent:<br>njury  |                     | 4 Donation 5 Other (Spe   |                                   | HOI                                 | -                            |  |                            | 04/12/2008                                      |                               |  |  |  |
| Bal                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinat must be notified at 90ce. | /                   | 21. Signalura of Fyreral Service Li   | Territory .                       |                                     | 1                            | Name and Addre<br>Bi<br>407 Old 1        | ruzdzi<br>Eastei           | Ínski Fune<br>rn Avenue,                        | ral Ho<br>Essex               | me, P.A<br>. Marvl                                       | and 21221  |  |
| .5                         |  |                     | 23a. Part 1. Priter the disease, or conshook, or heart failure. List or                                     | omplications that                 | caused the deat                     |                              |  |                            |   |                               |  | Approximate<br>Interval Between                  |  |
|                            | Physician  |                     | Immediate Cause (Final disease or condition   | ()                                | 2 im st                             | 4                            |  |                            |   |                               |  | Onset and Death                                  |  |
|                            | /Medical   |                     | resulting in death)   | Due to                            | (or as a consec                     | juence of):                  |  |                            |   |                               |  |  |  |
|                            | Examiner   |                     | Sequentially list conditions.   | b. Ce                             | Anora                               |                              | 13cte                                    | CV                         | Disco   | re                            |  |  |  |
|                            | pe #s  | luei                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to                            | (cras a conseq                      | uenus à c                    |  | 7                          |   |                               |  |  |  |
| 9.                         | cate be executed<br>physician and<br>the burial-transit  | Examiner            | that initiated events<br>resulting in Leath) Last   | c.<br>Due to                      | (or as a conseq                     | uence of):                   |  |                            |   |                               |  |  |  |
| 8760,                      | be e<br>Sician<br>buria  | alE                 |   |                                   |                                     | ,                            |  |                            |   |                               |  |  |  |
| 687                        | ficate<br>p physics<br>is the  | edical              |   | 0                                 |                                     |                              |  |                            |   |                               |  |  |  |
| Box                        | The law requires that the death certifi<br>ate has been signed by the attending<br>bage 2 should be detached for use as  | Physician/Me        | IF FEMALE:<br>23b. Was decedent pregnant  |                                   | stcome of pregna                    |                              | Te                                       |                            |   | 23                            | d. Date of deliv   | егу  |  |
|                            | death<br>e atte  | icia                | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Preg                            | birth 2 ☐ Feta<br>nant at time of c |                              | Ectopic pregnancy Other (specify) _      | ·                          |   |                               | Month  | Day Year   |  |
| 0.0                        | at the<br>by th  | hys                 | 9 ☐ Unknown   | 9□ Unkr                           |                                     |                              |  |                            | -   |                               |  |  |  |
|                            | es the   | by                  | Part II. Other significant condition  | s contributing to                 | _                                   | uiting in the u              | nderlying cause giv                      | en in Part I               |   |                               |  | he cause of death?                               |  |
| ord                        | w requir<br>been si<br>should  | ted                 | - KENBI   | FB1,                              | ure                                 |                              |  |                            | 1   | Yes 2                         | No 3 ☐ Prot  | oably 4/Sunknown                                 |  |
| Division of Vital Records, | law law las by a 2 st  | Completed           | Shope   | 2                                 |                                     |                              |  |                            |   | opsy                          | prior to co  | ppsy findings available<br>impletion of cause of |  |
| E =                        | : The<br>cate t  | Son                 |   |                                   |                                     |                              |  |                            | pe<br>1 ☐ Yes                                   | formed?<br>2 No               | death?<br>1 ☐ Yes  | 2 No   |  |
| Žį.                        | ician<br>sertifi<br>ector  | Be                  | 25. Was case referred to medical examiner?  | Hospital:                         |                                     |                              | . 0#                                     |                            | of Death Check on                               |                               |  |  |  |
| ot                         | ding Physician: The lav<br>h.<br>After this certificate has<br>funeral director, page 2  | 10                  | 1 ☐ Yes 2∕ No 27. Manner of Death   | 28a. Date                         | Inpatient 2                         | ER/Outpatier<br>28b. Time of |  |                            | rsing Home 5 Re                                 | sidence 6 (<br>a how injury o |  | (y)  |  |
| U                          | Attending Physician: or death. octor: After this certifics by the funeral director, I  | ton                 | 1 Natural 5 ☐ Pending   | (Moi                              | nth, Day Yeer)                      | Injury                       | Wor                                      | k?<br>Yes 2□               |   | a now injury                  | occurred   |  |  |
| 2                          | l or Attand<br>after death<br>Director: /  | flca                | 3 ☐ Suicide 6 ☐ Could no  | t be                              | e of Injury - At h                  | ome, farm, str               | eet, factory, office                     |                            |   | (Street and                   | Number or Run  | al Route Number,                                 |  |
| <u>S</u>                   | ± 15 €   | Certification;      | 4 Homicide  | build                             | ling, etc. (Special                 | (y)                          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                            | City or 1                                       | own, State)                   |  |  |  |
|                            | ospite<br>hours<br>inara<br>y fille  |                     | 29a. Certifier Certifying   | Physician: To th                  | e best of my kno                    | wledge, deatl                | h occurred at the tir                    | ne, date ar                | d place, and due to th                          | e cause(s) a                  | nd manner as s   | stated.  |  |
|                            | To the Hospital or Attan<br>within 24 hours after death<br>To the Funaral Director:<br>completely filled in by the   | edical              | (Check only 2 Medical E. one)   | kaminer: On the land mai          | basis of examina<br>nner stated.    | ation and/or in              | vestigation, in my o                     | pinion, dea                | th occurred at the tim                          |                               |  |  |  |
|                            | Vith<br>To t   | Σ                   | 29b. Signature and title of certifier   |                                   |                                     |                              | 29c. Licens                              | e number                   |   |                               | signed (Month,   | Day, Year)                                       |  |
| )                          |  | 1                   |   | 4                                 | MD                                  |                              | 2  | 2394                       | 65  | 41                            | 10/08  |  |  |
|                            | 1  | 1                   | 30. Name and ddress of person w   | ho completed cau                  | ise of death (Iter                  |                              |  | ^                          |   | _                             |  |  |  |
|                            | le   |                     | 31. Date filed (Month, Day, Year)   | MA                                | 7845                                | OK.                          | Rmogg                                    | 1201                       | ad Glev   | 1200                          | rie ins  | 7 91061  |  |
|                            | Sta<br>Registi   |                     | APR 1 1   | 2008                              | Aegistrar's Signa                   | Jr do                        | all                                      |                            |   |                               |  |  |  |
| A C                        | 3  |                     | 711 11 11   |                                   |                                     | -                            |  |                            |   |                               |  |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 04-09-2008 530 P <sup>M</sup> Jesse T. Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1005 Jessica Ct #C Harford Bel Air If Under 1 Year Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday 8. Date of Birth **Funeral** Months Days Hours 1 1 M 2 □ F 02-25-1928 Director 219-22-7701 80 TN Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nother any Injury or other transment." 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD **Funeral Director** 1 ☐ Yes 21 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Jessica Ct #C 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Brown Florence Good ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Jessica Ct #C Bel Air, MD 21014 Carrie P. Brown (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michael's Cemetery 04-14-2008 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Greviau 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A eral Director: A filled in by the fi 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month **Physician** Frances Emma Becker 8 April 2008 11:21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice - Dove House Carroll

9. Birthplace (State or Foreign Country) Westminster
If Under 1 Year | If Under 24 Hrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 ☐ M 2 🕶 F Months Days 91 8/26/1916 213-09-6303 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐Yes 2 No ns 23a or 28a-f sh must be notified Maryland Carroll Director Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 5418 Emerald Drive 23a 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces ↑ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ö Baltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 □ Divorced "natural", er than "natur , the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other tha Owner 6 Retail Gas and Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Bernard Hamson (unknown) Chanev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bernard S. Becker / Son 5418 Emerald Drive Eldersburg, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 4/11/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
1107 Wilkens Avenue Baltimore, MD 21. Signature of Funeral Service Licensee Mark T. 21229 Approximate Interval Between Onset and Death 23a, Part1. Enter the diseas, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Dug Conoe /Medical Due to or as consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine spital or Attending Physiclan: The law requires that the death certificate be executed ours after death.

In the control of the continuation of the attending physician and filled in by the untend director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but flot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ceretative 2 ₩ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) / PATIENT / TOSALE . 2**⊡** No Hospital: 3□ DOA Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 ☐ Pending investigation 1 TYes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled I 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Welley

State Registrar 31. Date filed (Month, Day, Year) 32. Pigistrar's S

1000 Liberty Road,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Eldersburg, Maryland 21157 Dr. P.Krueger

State Registrar 29b. Signature and title of certifier

KERITH

30. Name and address of person who comp

29d. Date signed (Month, Day, Year)

BALTIMORE, MD 21238

and manner stated.

eted cause of death (Item 23a) (Type, Print) 5601 Local

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                     |   |                 | State of Maryland / Department of F  1 - State Registrar  State of Maryland / Department of F  Certificate of  |   |                                 | giene<br>Reg. No.1     | 2008   | 11821                               |  |
|-------------------------------------|---|-----------------|--|---|---------------------------------|------------------------|--|-------------------------------------|--|
| À.                                  |   |                 | Decedent's Name (First, Middle, Last)  |   | 2. Date of De                   | ath                    |  | 3. Time of Death                    |  |
| Į.                                  | Physicia<br>/Medic  |                 | Gladys A. Becker   |   | April                           | B,                     | 2008   | 11:45 A <sup>M</sup>                |  |
| ·                                   | Examin  |                 |  | or Location of Death                    |                                 |                        | County of Deat                                 |                                     |  |
|                                     |   |                 | Oak Crest Care Center Baltimo:   |   |                                 |                        | altimor  |                                     |  |
|                                     | Funeral   |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year  Yrs. Months Days  | If Under 24 Hrs. Hours Min.             | 8. Date of Bir<br>(Month, Da    | y, Year)               | Co   | hplace (State or Foreign<br>ountry) |  |
| h                                   | Director  |                 | 212-09-3547 92   |   | Nov. 2                          | 1, 1                   | 915  | Maryland                            |  |
|                                     | yland<br>low<br>at  |                 | 10a. State 10b. County 10c. City, Town or Location   |   |                                 |                        |  | 10d. Inside City Limits             |  |
|                                     | a-f st  | ctor            | MD Queen Annes Stevensville  |   |                                 |                        |  | 1 ☐ Yes 2 No                        |  |
|                                     | th the<br>or 28   | Director        | 10e. Street and Number 10f. Zip Code   |   |                                 | 10g. Citiz             | zen of What Co                                 | ountry?                             |  |
|                                     | ath w   |                 | 120 Bay Drive 21666  |   |                                 | USA                    |  |                                     |  |
|                                     | er dez  | Funeral         | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of I If Yes, specify Cub   | Hispanic Origin? (Span, Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | -                      | <ol> <li>Race - Ame<br/>Black, Whit</li> </ol> |                                     |  |
| 36                                  | rs afte   |                 | 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give \( \) 3 ☑ Widowed 4 □ Divorced Year or Dates:  | Specify:                                |                                 |                        | Specify:                                       | white                               |  |
| Maryland 21215-0036                 | 2 hou<br>atura<br>cal Es  | Be Completed by | 15 Decedent's Education 16a, Decedent's Usual Occur  | pation                                  | . 11                            | 16b. Kir               | nd of Business                                 | 'Industry                           |  |
| 212                                 | hin 7%<br>9.<br>an "n<br>Medi   | ple             | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done life. DO NOT use retire                       | during most of work<br>ed)              | ring                            |                        |  |                                     |  |
| 2                                   | yd wit  | Com             | 12   Homemaker   | 1                                       |                                 | L                      | n Home   |                                     |  |
| D                                   | be file<br>tal Hy<br>d oth<br>event   | Be (            | 17. Father's Name ( <i>First, Middle, Last</i> )   | 18. Mother's Name                       | ,                               | , Maiden               | Surname)                                       |                                     |  |
| <u> </u>                            | nould<br>I Men<br>narke<br>natic  | ဠ               | James Kline  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street  | Louisa                                  |                                 | ar City a              | - Town State                                   | Zi- Codo)                           |  |
| ā                                   | d 2 sh<br>th and<br><b>7 Is n</b><br>traun  |                 |  |   |                                 |                        |  | zip Code)                           |  |
|                                     | Heal<br>Heal<br>tem 2   |                 | Lois B. Rys / daughter   120 Bay Drive   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)                   |   | Date                            | MD 2'<br>20c. Lo       | cation - City or                               | Town, State                         |  |
| ᅙ                                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                 | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 4 ☐ Other (Specify)  Moreland Memoria   | 1                                       | 1/08                            | Bol.                   | timore,  | MD                                  |  |
| altimore,                           | mit. Foartme  |                 | 21. Signature of Furieral Service Licensee 22. Name and Addres   |   | 1/00                            |                        | D50 Yor  |                                     |  |
| m                                   | Der<br>Imp  |                 | Ruck Tows  | on Funera                               | 1 Home                          |                        |  | MD 21204                            |  |
|                                     | 7 Duty  |                 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause an each line. | ing, such as cardiac                    | or respiratory a                | rrest,                 |  | Approximate<br>Interval Between     |  |
|                                     | Physician   |                 | Immediate Cause (Final disease or condition resulting in death)  |   |                                 |                        |  | Onset and Death                     |  |
|                                     | /Medical<br>Examiner  |                 | Due to (or as a consequence of):   |   |                                 |                        |  |                                     |  |
| 6                                   | Lxummer   | <u>_</u>        | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |   |                                 |                        |  |                                     |  |
|                                     | nsit // te  | Examiner        | cause. Enter Underlying  |   |                                 |                        |  |                                     |  |
| <u>,</u>                            | execunation and and and and and and and and and an  | Exar            | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):   |   |                                 |                        |  |                                     |  |
| 68760,                              | ificate be executed graphysician and stransit is the burial-transit   | edical          | d  |   |                                 |                        |  |                                     |  |
| _                                   | rtifical<br>ng phy<br>as th   |                 | IF STANKS.   |   |                                 | T                      |  |                                     |  |
| Š                                   | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as   | Physician/M     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  4 □ Live birth 2 □ Fetal death 1 □ Cher (mostlife)   | су                                      |                                 | 2                      | 23d. Date of de<br>Month                       | elivery<br>Day Year                 |  |
| 0                                   | ie des<br>the at<br>red fo  | sici            | 1  |   |                                 |                        | WOTH   | Day Tour                            |  |
| <u>.</u>                            | hat th  | Phy             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi   | ven in Part I.                          | 23e. Did 1                      | tobacco u              | se contribute to                               | o the cause of death?               |  |
| ds,                                 | signe<br>d be   | d by            | hyportensive heart disease, dementia   |   | 1 🗆                             | Yes 2[                 | No3 <u></u> P                                  | robably 4 🗹 Onknown                 |  |
| 50                                  | w requ  | Completed       | -310   |   | 24a. Was                        | an                     | 24h. Were a                                    | utopsy findings available           |  |
| æ                                   | he lav<br>e has<br>age 2 a  | ошо             |  |   | auto<br>perfe                   | psy<br>ormed?          | prior to death?                                | completion of cause of              |  |
| C                                   | an: T<br>tificat<br>tor, pa   |                 | 25. Was case referred to medical   | 26. Place of Deat                       | 1 Yes                           | 2 <b>⊡√</b> No<br>one) | 1 □ Yes  | s 2□No                              |  |
| 2                                   | hysician: The la<br>his certificate has<br>I director, page 2   | To Be           | examiner?  1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   | her: 4 Nursing Ho                       |                                 |                        | 6 □Other (Spe                                  | ecify)                              |  |
| 0                                   | ding Ph<br>n.<br>After th<br>funeral  |                 | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Wo   |   | 28d. Describe                   |                        |  |                                     |  |
| Sio                                 | eath.<br>or: A  | satic           | 2 Accident investigation M 1   | ]Yes 2□No                               |                                 |                        |  |                                     |  |
| Division or Vital Records, P.O. Box | To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as           | Certification:  | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                     | 1                                       | 28f. Location (<br>City or To   |                        |  | ural Route Number,                  |  |
|                                     | spital  |                 | 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the t  | time, date and place.                   | and due to the                  | cause(s)               | and manner a                                   | s stated.                           |  |
|                                     | e Hos<br>24 ho<br>e Fun<br>letely   | Medical         | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.  |   |                                 |                        |  |                                     |  |
|                                     | To the vithin To the comp   | Me              | 29b. Signature and title of certifier 29c. Licens  | se number                               |                                 | 29d. Dat               | te signed (Mon                                 | th, Day, Year)                      |  |
| )                                   |   |                 | De Mo  | 61785                                   |                                 | 41                     | 8/08   |                                     |  |
| -                                   | 12  |                 | 20. Name and address of parson who completed agus of death (Item 22a) (Type Print)   |   |                                 |                        |  |                                     |  |
|                                     | 1   |                 | Brosha Dixon MD 8800 Walther Blue  | d tarkvi                                | lle, MD                         | 212                    | 34   |                                     |  |
|                                     | Sta<br>Registr  |                 | Brosha Dixon MD 8800 Walther Blue  31. Date filed (Month, Day, Year)  APR 1 1 2008   |   |                                 |                        |  |                                     |  |
|                                     |   |                 | WIN TT CO.   |   |                                 |                        |  |                                     |  |

7/00/08 11/2m

Bucker, Gladys

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|            |   |                  | For<br>State<br>Registrar   | State of Mary  |                                       | tificate of D  |  |   | g. No. 2008                                  | 11822  |  |
|------------|---|------------------|---|--|---------------------------------------|--|--|---|--|--|--|
| Ţ          | Physici   | an               | Decedent's Name (First, Middle, Las     Paul John   | <sup>t)</sup><br>Bauer   |                                       |  |  | Date of Death     Month                 | Day Year                                     | 3. Time of Death                                   |  |
| 3.<br>(C)  | /Medic  | al               |   |  |                                       | 4b. City, Town, or I   |  | April E                                 | 4c. County of Deat                           | 10:12a <sup>M</sup>                                |  |
|            | Examin  | er               | 4a. Facility Name (If not institution, give 2300 Dulaney Val  | _  | -208                                  | Timonium   | Location of Death                              |   | Baltimore                                    |  |  |
| A          | Funeral   |                  | 5. Social Security Number 6. So   | ex 7. Age (In  | yrs. last birthday)                   | If Under 1 Year  | 1.1 0.4"                                       | 8. Date of Birth                        | 1 0 5  |  |  |
|            | Director  |                  | 213-24-0213   | ⊠M 2□F   8(  | Yrs.                                  | Months Days  | Hours Min.                                     | Jan. 28                                 | , 1928 M                                     | hplace (State or Foreign<br>untry)<br>aryland      |  |
|            | and w   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10   | c. City, Town or Lo                   | cation   |  |   |  | 10d. Inside City Limits                            |  |
|            | Maryla<br>f sho   | ō                | Md. Baltimo   |  | Timonium                              |  |  |   |  | 1 □Yes 2 No  |  |
|            | the 1   | rect             | 10e. Street and Number  |  |                                       | 10f. Zip Code  |  | 10                                      | g. Citizen of What Co                        | untry?   |  |
|            | h with  | Funeral Director | 2300 Dulaney Val  | ley Rd. F–20   | <b>38</b>                             | 21093  |  |   | USA  |  |  |
|            | ems a   | ner              | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?                                 | r in U.S. 13. \                       | Was Decedent of His<br>f Yes, specify Cubar                        | spanic Origin? (Spec                           | cify Yes or No-                         | 14. Race - Ame<br>Black, Whit                |  |  |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Medical Examiner must be notified at once. | þ                | 1 ☐ Never Married 24 Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                       |                                       | 1 □ Yes 2 <b>X</b> No  | Specify:                                       | ,                                       |  | hite   |  |
| 2-0        | 72 ho<br>'natur<br>dical  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. Deced                            | lent's Usual Occupa<br>kind of work done do<br>OO NOT use retired) | ition<br>uring most of workin                  | g 1                                     | 6b. Kind of Business/                        | Industry   |  |
| 121        | vithin<br>ne.<br>than "<br>ie Me  | фш               | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                       | oo not use retired)<br>Foreman                                     |  |   | Beth Ste                                     | <b>6</b> 1   |  |
|            | 12 should be filed within<br>h and Mental Hygiene.<br>7 is marked other than '<br>traumatic event, the Me   |                  | 17. Father's Name (First, Middle, Last)   |  | 16111                                 |  | 18. Mother's Name                              | (First, Middle, M                       |  | 61   |  |
| Maryland   | ld be<br>ental<br>ked o   | To Be            | George Bauer  |  |                                       |  | Barb   | ara Ku                                  | pfer   |  |  |
| ary        | shou<br>ind M<br>mar<br>umat  | -                | 19a. Informant's Name/Relationship (7   | ype. Print)  |                                       |  |  |   | City or Town, State, 2                       |  |  |
|            | and 2<br>salth s  |                  | Mrs. Margaret Bau   |  |                                       |  |  | . F-208                                 | Timonium,                                    | Md. 21093  |  |
| Baltimore, | Pages 1 and 2<br>ment of Health s<br>ant: If item 27 is<br>ury or other tra   |                  | 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □   | Hemoval from State   |                                       | sition (Name of<br>natory or other place                           |  |   | 20c. Location - City or                      | Town, State  |  |
| ţ          | Eant: Lant: Jury o  |                  | 4 □ Donation 5 □ Other (Specify   | ) [  |                                       | n Mem. Gd  |  |   | arriottsvi                                   | lle, Md.   |  |
| Bal        | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |                  | 21. Signature of Funeral Service Licen  | see  | 22                                    | Name and Address RUCK TOWS 1050 York                               | s of Facility<br>Son Funer<br>k Rd. Tow        | al Home,<br>son, Md.                    | Inc.<br>21204                                |  |  |
|            |   |                  | 23a. Part1. Enter the disease, or company shock, or heart failure. List only  | olications that caused the   | death. Do not ent                     | er the mode of dying   | g, such as cardiac or                          | r respiratory arre                      | st,  | Approximate<br>Interval Between<br>Onset and Death |  |
| N          | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)   | a. Co.   | onar                                  | Ar   | toy 1  | ) (seg                                  | 60   | Onset and Death                                    |  |
|            | /Medical<br>Examiner  |                  | resulting in dealiny  | Due to (or as a co   | onsequence of):                       | 11   | 1  | Fi                                      |  |  |  |
| Ы          | - 44  | er               | Sequentially list conditions, if any, leading to immediate  | b. Due to or as a co   | onsequence of):                       | e /7=  | <i>ea</i> (                                    | 1401                                    | ORE  |  |  |
|            | ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Pula   | neval                                 | y t  | 16505  | -3                                      |  |  |  |
| o,         | rifficate be executed and physician and as the burial-transit.  |                  | resulting in death) Last  | Due to (or as a co   | onsequence of):                       | -  |  |   |  | -  |  |
| 68760,     | ate be<br>hysici<br>the bu  | Medical          |   | d  | · · · · · · · · · · · · · · · · · · · |  |  |   |  |  |  |
|            | ertific<br>ling pl  | Mec              | IF FEMALE:  | COn If was autooms of a  |                                       |  |  |   |  |  |  |
| Box        | death cerl<br>e attendin<br>d for use   | Physician/       | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome pf p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim | Fetal death 3                         | Ectopic pregnancy Other (specify)                                  |  |   | 23d. Date of de<br>Month                     | ivery<br>Day Year                                  |  |
| O.         | 0 0   | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□Unknown  | o or death or                         |  |  |   |  |  |  |
| Δ.         | The law requires that the de<br>ate has been signed by the i<br>bage 2 should be defached   | by Pr            | Part II. Other significant conditions of  | ontributing to death but n   | ot resulting in the ur                | nderlying cause give   | n in Part I.                                   | 23e. Did tob                            | acco use contribute to                       | the cause of death?                                |  |
| Records,   | en sig  |                  |   |  |                                       |  |  | 1 □ Ye                                  | s 211 No 3 □ P                               | robably 4 □Unknown                                 |  |
| မင္ပ       | B 8 6   | Completed        |   |  |                                       |  |  | 24a. Was an                             | 24b. Were au                                 | utopsy findings available                          |  |
| <u>=</u>   |   | Com              |   |  |                                       |  |  | perform                                 |  | ·  |  |
| Vital      | Physiclan: Th<br>this certificate<br>ral director, pag  | Be               | 25. Was case referred to medical examiner?  | Hospital:  |                                       | Otho   | 26. Place of Death                             |   |  |  |  |
| or         | dii di  | . To             | 1  Yes 2  | 1 ☐ Inpatient 28a. Date of Injury                                      | 2 ER/Outpatien                        |  | 4 LI Nursing Hor                               |   | nce 6 Other (Spe                             | cify)  |  |
| O          | ding<br>I.<br>After<br>funel  | tion             | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day Ye   |                                       | Work   | es 2 □ No                                      | od. Describe no                         | w injury occurred                            |  |  |
| Division   | Attending<br>r death.<br>ector: After<br>by the fune  | fica             | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of injury   | - At home, farm, str                  | eet, factory, office   | 2  | 8f. Location (Str.                      | eet and Number or R                          | ural Route Number,                                 |  |
| Ö          | s after al Direction  | Certification:   | 4   nomiciae  | building, etc. (5  | эре <i>спу)</i>                       |  |  | City or Town,                           | , State)                                     |  |  |
|            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | Medical (        | 29a. Certifier (Check only one)  1 ★ Certifying Ph 2 ☐ Medical Example 1  | ysician: To the best of mainer: On the basis of exand manner stated    | amination and/or in                   | n occurred at the tim<br>vestigation, in my op                     | ne, date end place, a<br>pinion, death occurre | and due to the ca<br>ed at the time, da | use(s) and manner a<br>ate and place, and du | s stated.<br>e to the cause(s)                     |  |
|            | To the within To the complex  | Me               | 29b. Signature and tive of certifier  | /  |                                       | 29c. License   | number   | 29                                      | d. Date signed (Mont                         | h, Day, Year)                                      |  |
|            |   |                  | 11111   | we-  |                                       | Doo  | 2647   | 5 4                                     | 19/0   | 8  |  |
|            | ID  |                  | 30. Name and address of person who  | completed cause of death   | (Item 23a) (Type,                     | Print)   | 10   | 1/                                      | -0/  | 20   |  |
|            | 1   | _(               | SCOGE Le  | Cas  | Signature                             | 2  | 1(21   | (25F                                    | 50X /  | X  |  |
|            | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year)   | Sz. negistral/s  | Signature                             |  |  |   |  |  |  |

|  |                     | For State  |  | nt in Black In<br>aryland / Depa                            |   | lealth and M  | lental Hyg                                | _   | <b>e.</b><br>18   1823  |  |  |
|--|---------------------|--|--|---|---|---|---|---|---|--|--|
| Physici<br>/Medic  |                     | Registrar  1. Decedent's Name (First, Middle, La  HENRY N.   | BAKEI  | <b>R</b>  |   |   | 2. Date of Dea<br>Month<br><b>04–07</b> – | th<br>Day Y   | ear 3. Time of Death 6:48 P M   |  |  |
| Funeral<br>Director  | ner                 |  | R  | ge (In yrs. last birthday)<br>Yrs.                          | TOWSON  if Under 1 Year  Months Days  | If Under 24 Hrs. Hours Min.   |   | BALTIMORE  9. Birthplace (State or Foreign Country)         |   |  |  |
| the Maryland<br>r 28a-f show<br>notified at  | Director            | MD 10b. County  MD 10e. Street and Number  |  | 10c. City, Town or Lo                                       | 10f. Zip Code   |   | 1   | 0g. Citizen of Wha  | 10d. Inside City Limits 1 ★Yes 2 No at Country?   |  |  |
| Ind 21215-0036  be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or tiems 23a or 28a-f show event, the Medical Examiner must be notitied at  | by Funeral          | 110 N. CENTRAL A  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent<br>Armed Forces'<br>1y Yes 2 Unif Yes, Give<br>Year or Dates: | Ever in U.S. 13. No   | Was Decedent of H<br>If Yes, specify Cuba<br>1 □ Yes 2 1 2 No                 | SALTIMORE<br>ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)          | Black,  | USA<br>American Indian,<br>White, etc.<br>BLACK   |  |  |
| d 21215-0036<br>filed within 72 hours af<br>Hygiene.<br>ther than "natural", or<br>ont, the Medical Exam   | Completed           | 15. Decedent's E<br>(Specify only highest gi<br>Elementary/Secondary (0-12)  | College (1-4or   | 5+) (Give   | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>EPRENEUR     | during most of work   | ding                                      |   | AUTY SALONS   |  |  |
| ~ o ~ o >  | To Be               | 17. Father's Name (First, Middle, Las<br>HENRY BAKER  19a. Informant's Name/Relationship   |  | 19b. Maili  | i   | LORETTA (   |   | y or Town, State, Zip Code)                                 |   |  |  |
| Baltimore, Marylar permit. Pages 1 and 2 should be permit. Pdeath and Menti Important: If them 27 is marked any highry or other traumatic e once.  |                     | AMY BAKER/DAUGHT  20a. Method of Disposition  1 X Burial 2 Cremation 3 I 4 Donation 5 Other (Spec 2 Signature of Funeral Service Lice  | PER  ☐Removal from State   | 8209 20b. Place of Dispo<br>cemetery, cre-                  | FEATHERS position (Name of matory or other place  VET . CEM 2. Name and Addre | IILL RD.,   | APT 104  Date 6-2008 0  MES A. M          | PERRY 20c. Location - Ci WINGS MI ORTON &                   | HALL, MD21128 ty or Town, State  LLS, MD  SONS F.H., INC                                |  |  |
| Physician when the executed the price of the | ical Examiner       | 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on se on each line.  Approximate Interval Betwee Onset and Det disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  |  |   |   |   |   |   |   |  |  |
| O. BOX 687¢ the death certificate b the attending physic   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown  |  |   |   |   |   |   |   |  |  |
| Hecords, P.O. The law requires that the date has been signed by the bage 2 should be detached  | by                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown  |  |   |   |   |   |   |   |  |  |
| The lay  | Be Completed        | 25. Was case referred to medical   |  |   |   | 26. Place of Deat   |   | med? dea<br>2 2 0 1   | ere autopsy findings available<br>or to completion of cause of<br>ath?<br>Yes 2 \sum No |  |  |
| DIVISION Or VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,  | Certification: To E | examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigation investigation of the determined investigation of | 28e. Place of in   | ury 28b. Time o   | of 28c. injur<br>Wor<br>M 1   | 4 U Nursing H   | 28d. Describe h                           | ence 6 Mother ow injury occurred treet and Number n, State) |   |  |  |
| ne Hospital<br>n 24 hours a<br>he Funeral<br>pletely filled  | edical Ce           |  |  | of my knowledge, deat<br>of examination and/or in<br>tated. |   |   |   |   |   |  |  |
| ,  | Me                  | 29b. Signature and title of certifier  30. Name and address of person who  | M Liley<br>completed cause of  | death (Item 23a) (Type,                                     | 29c. Licens   | -5205   |   | Page 1 Date signed (  | Month, Day, Year)   |  |  |
| 3 <sup>X</sup> \<br>Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year)  APR 112   | 32 Pegist  | rar's Signature   | Print)<br>Charles   | St. Balt  | to, md                                    | 21209   | <del>f</del>  |  |  |
| DHMH 17 Rev 1/2  | 001                 |  | , , ,  | 6   |   |   |   |   |   |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** APR 8 2008 3:05 PATRICIA ANN BREEN Α /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 14, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min Country) Months Hours 1 □ M 2 🗓 F 82 1925 273-26-4949 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event than "the status". 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 X Yes 2 ☐ No Director Maryland Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20879 11900 Kinglet Place United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Mor1ev E11a Ehrlich ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia B. Dolan / Daughter 5519 Uppingham Street, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place Arlington National Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) April 24,2008 Arlington, Virginia 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, SANOX M01193 300 W. Montgomery Ave., Rockville, MD 20850 art1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 ₹ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler Medical (Check only 29b. Signature and title)of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101242364 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 NATIONAL NAVAL MEDICAL CENTER ANDRES NIETO LT USN MC BETHESDA MD 20889-5600 2. Registrar's Signature 31. Date filed (Month, Day, Year) State DOM! Registrar APR 11 2008 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                                | For<br>State<br>Registrar  | Plea                                       |                              |  |  | d / Dep               | delible Inkartment of<br>rtificate of              | Health and                               |   |                     | e2 0 0 8                                | 11825  |
|---------------------|--|--------------------------------|--|--|------------------------------|--|--|-----------------------|--|--|---|---------------------|---|--|
| I                   | Physici<br>/Medic  | _                              | 1. Decedent's Nam Delores  |  |                              |  |  |                       |  |  | 2. Date of I<br>Month<br><b>Apri</b>    | D                   | Year <b>2008</b>                        | 3. Time of Death 9:15 AM M                         |
| 统                   | Examir   |                                | 4a. Facility Name (i   |  | n, give stre                 | et and number  | )                                      |                       | 4b. City, Town,                                    | or Location of De                        | eath                                    | 4                   | c. County of Death                      |  |
|                     |  |                                | Casey H  |  | 1                            |  |  |                       | If I and a d Van                                   | Derwoo                                   |   |                     | Montgome                                |  |
|                     | Funeral<br>Director  |                                | 5. Social Security N   | 2032                                       | 6. Sex<br>1 ☐ M              |  | ge (In yrs. la<br>73                   | ast birthday)<br>Yrs. | Months Days  |  | Irs. 8. Date of E<br>(Month, I<br>09/3  | Day, Yea<br>0/19    | 9. Birth Cou                            | place (State or Foreign<br>ntry)                   |
|                     | and www.   |                                | Usual Residence o<br>10a. State  | 10b. Count                                 | /                            |  | 10c. City                              | , Town or Lo          | ocation  |  |   |                     |   | 10d. Inside City Limits                            |
|                     | Maryl<br>f sho<br>ied a  | ō                              | MD   | Mont                                       | gomer                        | v  | Si                                     | lver s                | Spring   |  |   |                     |   | 1 ☐ Yes 2 No                                       |
|                     | 28a-   | rec                            | 10e. Street and Nu   |  | •                            |  |  |                       | 10f. Zip Code                                      |  |   | 10g. C              | Citizen of What Cou                     | ntry?  |
|                     | h with   | O Ie                           | 1120 Cr  | owfoot                                     | Lane                         |  |  |                       | 20904  | <u> </u>                                 |   | U                   | nited Sta                               | ites   |
| "                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at  | Funeral Director               | 11. Marital Status 1 □ Never Mari  | ried 2 🔀 Ma                                | rried                        | Was Deceden<br>Armed Forces<br>1 ∐Yes 2 🔀                      | ?                                      |                       | Was Decedent of<br>If Yes, specify Cu              |  | (Specify Yes or I<br>lerto Rican, etc.) | No-                 | 14. Race - Ameri<br>Black, White        |  |
| 93                  | rurs a<br>ral', o<br>Exam  | þ                              | 3 Widowed  | 4 Divorce                                  | 1                            | If Yes, Give<br>Year or Dates                                  |  |                       | 1 ☐ Yes 2 🗷 No                                     | Specify:                                 |   |                     | Specify: Wh:                            | ite  |
| 20                  | 72 ho<br>natur<br>fical  | eted                           | (Spe   | 15. Decede                                 | nt's Educati                 | on<br>mpleted)   |  | 16a. Dece             | dent's Usual Occu                                  | upation                                  | workina<br>workina                      |                     | Kind of Business/Ir                     | ndustry  |
| 2121                | within Jiene. r than "I  | Completed                      | Elementary/Seco  |  | ī                            | College (1-4o  | · 5+)                                  | Nurs                  | e kind of work done<br>DO NOT use retire<br>C      | ed)                                      | ronning                                 | M                   | edicine                                 |  |
| Maryland 21215-0036 | d be filed<br>ental Hyg<br>ced othe<br>c event,  | Be                             | 17. Father's Name<br>Gordon  |  | , Last)                      |  |  |                       |  | 18. Mother's N                           | Name (First, Midd<br>hy Fine            | le, Maide           | en Surname)                             |  |
| lary                | 2 shoul<br>and Me<br>Is mark<br>aumati   | ဥ                              | 19a. Informant's N   |  |                              |  |  |                       | _  |  |   |                     | y or Town, State, Zi                    |  |
| 2,5                 | and<br>lealth<br>m 27<br>her tr  |                                |  |  | s/nusp                       | and  | Loo. D                                 |                       |  |  |   | -                   | ng, MD 20                               |  |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                                | 20a. Method of Dis<br>1 ☐ Burial 2<br>4 ☐ Donation   | ■ Cremation                                |                              | oval from Stat   | e                                      |                       | osition (Name of<br>matory or other pl<br>ake Crem |  | Apr 11<br>2008                          |                     | Location - City or T<br>eltsville,      |  |
| Balt                | permit. Departr Importa any Inju   |                                | 21. Signature of F   | uneral Service                             | 411                          | nan  | M00.                                   | 38 <b>2</b> 2         | 2. Name and Add<br>Rapp Fune<br>933 Gist           | ress of Facility<br>eral & Cr<br>Ave. Si | emation S<br>lver Spri                  | ervi                | ces<br>Maryland 2                       | 20910-   |
|                     | Physician<br>/Medical<br>Examiner  |                                | Immediate Cause<br>disease or condition<br>resulting in death)   | art failure. Lis<br>(Final<br>on           | or complicated only one of a | ause on each  Due to (or a                                     | s a consequ                            | cestra<br>ience of):  |  | ving, such as care                       |   | arrest,             |   | Approximate<br>Interval Between<br>Onset and Death |
| 8760F/              | cate be executed physician and the burial-transit  | dical Examiner                 | Sequentially list or<br>if any, leading to ir<br>cause. Enter Undi<br>Cause (Disease or<br>that initiated event<br>resulting in death) | mmediate<br>erlying<br>injury<br>s<br>Last | d                            | Due to (or a   |  |                       |  |  |   |                     |   |  |
| P.O. Box 687        | Attending Physician: The law requires that the death certificate I releath. r death. ector: After this certificate has been signed by the attending physis by the funeral director, page 2 should be detached for use as the L   | Completed by Physician/Medical | IF FEMALE:<br>23b. Was deceder<br>in the past 12<br>1 ☐ Yes 2<br>9 ☐ Unknown   | nonths?<br>■No                             | 23c.                         | If yes, outcom<br>1 □Live birth<br>4 □ Pregnant<br>9 □ Unknown | 2 Fetal                                | death 3[              | ⊒Ectopic pregnan<br>⊒ Other <i>(specify)</i> .     | су                                       |   |                     | 23d. Date of deliv                      | very<br>Day Year                                   |
| rds, P              | w requires that<br>s been signed b<br>should be deta   | d by Pr                        | Part II. Other signi   | ificant condit                             | ions contrib                 | uting to death   | but not resu                           | liting in the u       | ınderlying cause g                                 | iven in Part I.                          |   |                     | o use contribute to<br>2 □ No 3 □ Pro   | the cause of death?                                |
| Vital Records,      | Physician: The law re<br>r this certificate has bee<br>ral director, page 2 shor   | omplete                        |  | =  |                              |  |  |                       |  |  | 24a. Wa<br>au<br>pe<br>1□ Yes           | topsy<br>rformed    | prior to condeath?                      | topsy findings available completion of cause of    |
| ita                 | ilan:<br>ertifica<br>ctor, I   | Be C                           | 25. Was case refe<br>examiner?   | rreg to medic                              | _                            |  |  |                       |  | 26. Place of                             | Death (Check onl                        | v one)              |   |  |
| <u> </u>            | hysto<br>his ce<br>I direc   | ToE                            | 1 ☐ Yes 2 ☑  | No   | Hos                          | oital:<br>1 ☐ Inpa   | tient 2 🗆 I                            | ER/Outpatie           | III 3 DOA  |  | g Home 5□Re                             | sidence             | 6 Other (Spec                           | in Hospice 184                                     |
| Division or         | ending Ph<br>ath.<br>or: After th  | ation:                         | 27. Mannef of Dea<br>1 ☑ Natural<br>2 ☐ Accident   | 5 ☐ Pendi<br>invest                        | ng<br>tigation               | 28a. Date of In<br>(Month, E                                   | jury<br>Pay Year)                      | 28b. Time o<br>Injury | W  | ury at<br>ork?<br>⊒ Yes 2 □ No           | 28d. Describ                            | e how in            | jury occurred                           | 1  |
| Divis               | To the Hospital or Attend within 24 hours after death. To the Funeral Director: /  | Certification:                 | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Could deter                            | not be<br>nined              | 28e. Place of in<br>building,                                  | njury - At ho<br>etc. <i>(Specif</i> y | me, farm, st          | reet, factory, office                              | Э  | 28f. Location<br>City or 1              | (Street<br>own, Sta | and Number or Ru<br>ate)                | ral Route Number,                                  |
|                     | To the Hospital or within 24 hours afte To the Funeral Dir   | Medical C                      | 29a. Certifier<br>(Check only<br>one)  |  |                              |  | of examinat                            |                       |  |  |   |                     | (s) and manner as<br>and place, and due |  |
|                     | Го the within Го the хотры   | Me                             | 29b. Signature and   | title of certifi                           | e/                           | 10   | 1                                      |                       | 29c. Licer   | nse number                               |   | 29d. [              | Date signed (Month                      | , Day, Year)                                       |
|                     | ->-0   |                                | > Ale  | nae  | Uplu                         | Wow  | sk in                                  | )                     | 1  | 0064                                     | 615                                     |                     | 4-9                                     | -08  |
|                     | $\theta$   |                                | 30. Name and add   | ress of person                             | who comp                     | leted cause of   | death (Item                            |                       | Print) Murcas                                      | forMil                                   | IRd =                                   | Roce                | ville M                                 | d 20850  |
|                     | ∜ Sta  | te                             | 31. Date filed (Mor  | nth, Day, Year                             | )                            | 32. Regis  | trar's Signa                           |                       | V-   | V  |   | 3                   |   |  |

State Registrar

DHMH 17 Rev 1/2001

SK NJ 6001 Nunc ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤉 🕦 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:00 PM April 10, 2008 Albert Frank Collins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 300 Felton Road Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Hours Min. Days **₩** 2□ F 85 Director England 09/11/1922 212-40-0636 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Lutherville Timonium Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a United States 21093 Funeral 300 Felton Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 21≦No Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Year or Dates White Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automotive Elementary/Secondary (0-12) College (1-4or 5+) Master Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Maude Bull Albert Edward Collins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aleida Collins/ Wife <u>300 Felton Road, Lutherville, MD 21093</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04.11.08 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD1443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earth line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liter to deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be exect Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) ned by the a detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗗 Cerlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and little

31. Date filed (Month, Day, Year)

APR 11

32. egistrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

In F. MAC, MD 1447 York Rd. Lutherville, MD 21093

29d. Date signed (Month, Day, Year)

|                            |   |                     | 1 - For amend #19a  | State of L<br>&b Per I   | Marylan<br>NF G87                   | d / Depa<br>8 4 29   | artmen<br>708<br>rtificat  | t of H<br>IH<br>e of L      | ealth a<br>D <i>eath</i>               | nd Men                      | ntal Hygi                         | ene 008   | 11827   |
|----------------------------|---|---------------------|---|--|-------------------------------------|--|----------------------------|-----------------------------|--|-----------------------------|-----------------------------------|---|---|
|                            | D!  |                     | 1. Decedent's Name (First, Middle, La.  |  |                                     |  | -                          |                             |  | 2                           | Date of Death                     | 11  | 3. Time of Death                                |
|                            | Physici<br>/Medic   |                     | Josephine   | M. Cleme   | ens                                 |  |                            |                             |  | Aï                          | Month<br>oril 8,                  | 2008  | 9:33 A.M  |
|                            | Examin  |                     | 4a. Fecility Name (If not institution, given Glen Meadows   | e street and numb  | er)                                 |  | ,                          | Town, or<br>len             | Location of<br>Arm                     | f Death                     |                                   | 4c. County of Death<br>Baltimon                         |   |
|                            | Funeral<br>Director   |                     | 5. Social Security Number 089-07-3635 6. S  | ex 7.<br>□M 2໘F  |                                     | last birthday)<br>90 Yrs.  | If Under<br>Months         | 1 Year<br>Days              | If Under 2<br>Hours                    | Min.                        | Date of Birth<br>Month, Day,      |   | nplace (State or Foreign<br>untry)<br>LC11y     |
|                            | pur *   |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c Cit                             | y, Town or Lo  | ocation                    |                             |  | -                           |                                   | •   | 10d. Inside City Limits                         |
|                            | Manyta<br>4 sho   | ro                  | Maryland Baltim   | ore  |                                     | Glen   |                            |                             |  |                             |                                   |   | 1 □ Yes 2√2No                                   |
|                            | n 28a   | irec                | 10e. Street and Number  |  |                                     |  | 10f. Zip                   |                             |  |                             | 10                                | g. Citizen of What Co                                   | untry?  |
|                            | ith witi  | aiD                 | 11630 Glen Arm  | Road   |                                     |  |                            | 2105                        | 7                                      |                             |                                   | United Sta<br>of America                                |   |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any righty or other traumatic evant, the Medical Examiner must be notified at ODGs. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced   | 12. Was Decede<br>Armed Force<br>1 Tes 2<br>If Yes, Give<br>Year or Date | ss?<br>☑ <b>K</b> No                |  | Was Deced<br>If Yes, spec  | ofy Cuba                    | spanic Orig<br>n, Mexican,<br>Specify: | in? (Specify<br>Puerto Rica | Yes or No-<br>an, etc.)           | 14. Race - Ame<br>Black, White<br>Specify: \(\sqrt{1}\) |   |
| 8                          | 2 hou   | ted                 | 15. Decedent's Ed   | lucation   |                                     | 16a. Dece  | dent's Usua                | I Occupa                    | tion                                   |                             | 1                                 | 6b. Kind of Business/                                   | ndustry   |
| 212                        | thin 7;   | Completed           | (Specify only highest gra   | de completed) College (1-4   | or 5+)                              | life.  | DO NOT us                  | se retired,                 | uring most                             | of working                  |                                   | 717.0   | -td-v   |
| 7                          | ygien<br>ygien<br>rt. The   |                     |   |  |                                     | su   | pervi                      | sor                         |  |                             |                                   | stern Elec  | etric   |
| Maryland 21215-0036        | uld be fil<br>Mental H<br>irked oth<br>itic evan  | To Be               | 17. Father's Name (First, Middle, Last) Thomas Mauro  |  |                                     |  |                            |                             |  | ,                           | la Aufi                           | aiden Sumame)<br>_ero                                   |   |
| Man                        | alth and I  |                     | 19a Informants Name/Relationship (<br>John C. Clemens<br>Christina Marcale  | Type, Print)<br><b>/ spouse</b><br>k/ daugh                              | ter-                                | 19 <b>1 63</b>   | )º <b>Gres</b><br>Butt     | (Street a<br>ATT            | Rd Number                              | Apt 1                       | 1'3 <sup>N</sup> GTe              | City or Jown Mile 2<br>MAIN Mary La                     | 1657<br>10 21707                                |
| ore,                       | es 1 a of He of He fitem  |                     | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □   | Removal from Str   | 20b. F                              | Place of Disponentery, cremetery, cremetery, Cremetery, Cremetery, Cremetery, Cremetery, Cremeters, Company, Cremeters, C | sition (Nan                | ne of<br>ther place         | 2) 7                                   | Dete<br>pril 1              |                                   | Oc. Location - City or                                  | Fown, State                                     |
| Ĕ                          | Pag<br>ment<br>ant: i   |                     | `4 □ Donation 5 □ Other (Specif   |  | Mem                                 | orial  | Garde                      | ns                          |  | 2008                        | .,                                | limonium, I   | <del></del>                                     |
| Baltimore,                 | permit. Depart Import any in  |                     | 21. Signature of Furferal Service Lice  | X/   |                                     |  | 2325                       | Yor                         | k Roa                                  | d Tir                       | nonium.                           | Harvland  | ion Ctr.,P.7<br>21093                           |
| g.                         | Physician /Medical Examiner   | Examiner            | 23a. Part1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or c.   | as a conseq as a conseq as a conseq | uence of):   | er the mod                 | e of dying                  | g, such as c                           | eardiac or re               | spiratory arres                   | st,   | Approximate Interval Between Onset and Death    |
| .O. Box 68760,             | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 m hths? 1 □ Yes 2 W No 9 □ Unknown   |  | n 2 □ Feta<br>tattime of d          | Ideath 3□  | Ectopic pr                 |                             |  |                             |                                   | 23d. Date of deli<br>Month                              | very<br>Day Year                                |
| ds, P.                     | w requires that<br>s been signed b<br>s should be deta  | l by Pt             | Part II. Other significent conditions of  | ontributing to deat  | h but not res                       | ulting in the u  | nderlying c                | ause give                   | n in Part I.                           |                             |                                   | acco use contribute to                                  |   |
| Division of Vital Records, | The law requate has been page 2 shoul   | Completed by        | Cotetro vascular a  | disease  | ٠                                   |  |                            |                             |  |                             | 24a. Was an autopsy perform       | a prior to c  | topsy findings available completion of cause of |
| Vita<br>Vita               | ician:<br>sertific<br>actor,  | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |                                     |  |                            | Otho                        |  |                             | neck only one                     |   |   |
| o                          | Phys<br>r this<br>ral dir   | 7                   | 1 Yes 2 No 27. Manner of Death  | 1 🗆 Inp  |                                     | ER/Outpatier<br>28b. Time of   |                            |                             | 4 🗆 (40):                              |                             | 5 Describe how                    | ice 6 Other (Spec                                       | sify)   |
| 0                          | ding<br>th.<br>Atter  | tion                | 1 ■ Natural 5 □ Pending 2 □ Accident investigation  | 28a. Date of (Month,   | Day Year)                           | Injury   | м                          | 8c. Injury<br>Work<br>1 🗆 Y | ?<br>′es 2 □ N                         |                             | 000011001101                      | injury occurred   |   |
| Divisi                     | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2   | Certification;      | 3 Suicide 6 Could not be determined   | 28e. Place of  | Injury - At ho<br>, etc. (Specif    | ome, farm, str   | eet, factory               | r, office                   |  | 28f.                        | Location (Stre<br>City or Town,   | eet and Number or Ru<br>State)                          | ral Route Number,                               |
|                            | a Hospita<br>24 hours<br>a Funera<br>eteky filka  | Medical C           | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medicel Exam   | ysician: To the be<br>niner: On the basi<br>and manner                   | s of examina                        | wledge, death<br>tion and/or in  | h occurred<br>vestigation, | at the tim                  | e, date and<br>inion, death            | place, and<br>h occurred a  | due to the car<br>t the time, dat | use(s) and manner as<br>se and place, and due           | stated.<br>to the cause(s)                      |
|                            | To th<br>Within<br>To th  | Me                  | 29b. Signature and title of certifier   | M  | nn                                  |  | 290                        | License                     | number                                 |                             | 29<br>A                           | d. Date signed (Month                                   | OOX   |
|                            | W   |                     | 30. Name and address of person who  | completed dauge  | of death (item                      | 23a) (Type,  | Print)                     | 30                          | R.16                                   |                             | 011                               | fort 8, 2<br>2204                                       |   |
|                            | Sta   | te                  | M. DAY M. Cr3  31. Date filed (Month, Day, Year)  | 11. 6 TO   | Strar's Signa                       | ture,  | 100                        | ,                           | auc                                    | more                        | 1016                              | 444   |   |
|                            | Registr   |                     |   | 2008   | 800.10 A                            | H. A   | MARKE                      | 1                           |  |                             |                                   |   |   |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician APRIL MOLLIE B COHEN 2008 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6622 VINCENT LANE #103 BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 90 215-30-2886 10/13/1917 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6622 VINCENT LANE, #103 21215 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Specify: WHITE 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HOUSING AND Elementary/Secondary (0-12) 12 College (1-4or 5+) URBAN DEVELOPMENT ADMINISTRATIVE ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( MORRIS COHEN YETTA UNOBTAINABLE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7321 KERRY HILL COURT, DONALD COHEN / SON COLUMBIA, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RODFE ZEDEK 04/10/2008 BALTIMORE, MD 21. Signat e of Funeral Septice Door e SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Years Due to (or as a consequence of): ypertension Sequentially list conditions, if any, leading to infinite duate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Day 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Decubitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

burial-trar ed by the attending physician detached for use as the buria funeral director, this After t To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

28a-f sh notified

ms 23a or must be r

"natural", or items

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once."

**Physician** 

/Medical

Examiner

and

Baltimore, Maryland 21215-0036

Pages '

29a. Certifier

(Check only one)

29b. Signature and title of certifier

6 Could not be determined 3 Suicide 4 Homicide

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

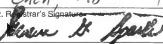
PO Box 19099,

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 2008

(exander



To the Hospital within 24 hours at To the Funeral D

# **Physician** /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 De Rosiers, Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Division or Vital Records, P.O. Box 68760,

| Registrar  |  | Ì  | State of Ma   | aryland /  | Department<br>Certificate  | r or Health and<br>e <i>of Death</i>   | a Mental Hy   | rgiene<br>Reg. No. 2 (   | 108 1182   |
|--|--|--|---|--|--|--|---|--|--|
| . Decedent's Name  | e (First, Middle   | e, Last)   |   |  |  |  | 2. Date of De   | -  | 3. Time of Death   |
| Frances  | Cather   | cine   | Desrosia  | ers  |  |  | April   | 08 200   | N  |
| a. Facility Name (li<br>Greater  | f not institution<br>Balt:   | i, give str<br>imor  | reet and number)<br>e Medic   | cal Ce   | nter T   | Town, or Location of Do  | eath  | 4c. County<br>Balt   | of Death<br>imore  |
| Social Security N  |  | 6. Sex<br>1 ☐ I  | 7. Age  | e (In yrs. last bi   | Yrs. If Under Months   |  | lin. (Month, D.   | rth<br>ay, Year)<br>3-1911   | Birthplace (State or Foreig Country)   |
| 12-36-53<br>sual Residence of  |  |  |   |  |  |  | 12-2.   | 3-1911   | Md.  |
| a. State   | 10b. County  |  |   | 3,   | wn or Location   |  |   |  | 10d. Inside City Limit   |
| Md.<br>De. Street and Nur  | Balto  | ) •  |   | P.   | arkville<br>10f. Zip   | Codo   |   | 10g. Citizen of  |  |
| 8439 W   |  | ak Ro  | 1.  |  | 101. Zip   | 21234  |   | •  | USA  |
| Marital Status     □ Never Marri   | ied 2□ Marr  |  | 2. Was Decedent I<br>Armed Forces?<br>1 ☐ Yes 2 ☐ N<br>If Yes, Give X   |  |  | lent of Hispanic Origin?<br>ify Cuban, Mexican, Pi   | (Specify Yes or Nuerto Rican, etc.)   | Bla  | ce - American Indian,<br>ck, White, etc.<br>White  |
| 3 ₩idowed  | 4 ☐ Divorced   | t'a Educa  | Year or Dates:  |  | 1 ☐ Yes 2<br>a. Decedent's Usua  |  |   | Special Specia | tusiness/Industry  |
| (Spec  | cify only highe  | st grade   | completed) College (1-4or 5   |  |  | k done during most of  | working   | TOD: KING OF E   | daniess/muusti y   |
| 6th  |  |  |   | <u> </u>   | Homema   |  | N (5'1 Adi-1-11   | Home   |  |
| 7. Father's Name (<br>Samue1 1   | •  | ,  |   |  |  |  | Name (First, Middle   |  | ne)  |
| 9a. Informant's Na   |  |  | e. Print)   | 19   | b. Mailing Address   | (Street and Number of  | nna Grice r Rural Route Numi  |  | , State, Zip Code)   |
| Marlene V  | Wood (   | Grand  | lDaughtei   |  |  | crans Pl.  | Apt.2C  | Perry Ha   | 11 21236   |
| Da. Method of Disp   |  | 3 ∏Rei   | moval from State  | 20b. Place o   | of Disposition (Nan<br>ery, crematory or o   | ne of<br>ther place)   | Date  | 20c. Location  | - City or Town, State  |
| 4 Donation  1. Signature of June   | 5 Other (S   | pecify)  |   | Most   |  | leemer 4-1   | 2-2008  | В  | alto. Md.  |
| 140  | 164  |  |   |  | Schimur  | nek Funeral  | Home  |  |  |
| oquentially list se  | nditions   |  |   |  |  |  |   |  |  |
| any, leading to im<br>ause. Enter Unde<br>ause (Disease or   | nmediate<br>erlying<br>injury  | <b>b</b> .   | Due to (or as   | a consequence  | e of):   |  |   |  |  |
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| any, leading to make. Enter Under ause. Enter Under ause. Chisease (Disease variation in the interest of the i | t pregnant ponths?  It pregnant ponths?  No  ficant condition  Fic | g attion not be inned Examine  | Due to (or as.  c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ributing to death birth 28a. Date of Inju (Month, Day) 28e. Place of inju building, etc.   | pf pregnancy 2   | th 3 Ectopic pr 5 Other (sp in the underlying case)  outpatient 3 DO  Time of Injury M farm, street, factory  ge, death occurred and/or investigation  | 26. Place of  A Other: 4 Nursin  8c. Injury at Work? 1 Yes 2 No  7, office  at the time, date and p, in my opinion, death of | 24a. Wa: autr perl 1  | tobacco use con  Yes 2 No  s an ppsy formed? 2 No  sidence 6 Ot how injury occu  (Street and Num wm, State)  e cause(s) and m e, date and place  | onth Day Year  tribute to the cause of death?  3 Probably 4 Unknow  Were autopsy findings availab prior to completion of cause of death?  1 Ves 2 No  her (Specify)  rred  ber or Rural Route Number,  |
| any, leading to mause. Enter Under ause. Enter Under ause. (Disease value) at initiated events esulting in death) I.  FFEMALE: 3b. Was decedent in the past 12 1   Ves 2 9   Unknown art II. Other significant in the past 12 1   Ves 2 9   Unknown art II. Other significant in the past 12   Ves 2 9   Unknown art II. Other significant in the past 12   Ves 2   Ve | t pregnant ponths?  It pregnant ponths?  No  ficant condition  Fic | Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho Ho H   | Due to (or as.  c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ributing to death birth 28a. Date of Inju (Month, Day) 28e. Place of inju building, etc.   | pf pregnancy 2 Fetal deat time of death  at not resulting  of 1 2 ER/O  y y Year)  28b.  gry - At home, f c. (Specify)  of my knowledge is examination a ted.  | th 3 Ectopic pr 5 Other (sp in the underlying case)  outpatient 3 DO  Time of Injury M farm, street, factory  ge, death occurred and/or investigation  | 26. Place of  A Other: 4 Nursir  8c. Injury at Work? 1 Yes 2 No  , office  at the time, date and p, in my opinion, death of  | 24a. Wa: autiper 1 Yes  Death (Check only 1g Home 5 Res 28d. Describe  28f. Location City or To     | tobacco use con  Yes 2 No  s an ppsy formed? 2 No  sidence 6 Ot how injury occu  (Street and Num wm, State)  e cause(s) and m e, date and place  | onth Day Year  Intribute to the cause of death?  Trobably 4 Unknow  Were autopsy findings availat prior to completion of cause of death?  Under (Specify)  Tred  Inter (Specify)  Tred  Dear or Rural Route Number,  Janner as stated.  Janner as stated.  Jand due to the cause(s)  Jand (Month, Day, Year) |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 6:52 PM 2008 nlev /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Samaritan Hospital Good If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
3-10-1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 128M 2□ F 860 Yrs. 212-14-9636 maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1 ☐ Yes 2 ☑ No Directo Baltimore Parkvill MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 212 8712 Maravoss Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Seyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) School 12 eacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Demski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trau Parkville MD 21234 8712 Marayoss L Amelia Demoki 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ■ Burial 2 □ Cremation 3 □ Removal from State Holy Rosan Cometer 4-10-2008 Hialtimore 122. In me and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville
Evans Funeral Chapel + Cremation Services - Parkville
8800 Harford Road Parkville mD 21234

Approximate Interval Between Onest and Death 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses lautio 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to ( as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No hemorrhage 24a. Was an autopsy pertormed? ate has bage 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 No 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 27: Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 80-+0-10 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coch Raven Blva, Baltimore AMIR KAZORY, 5601

DHMH 17 Rev 1/2001

State Registrar 32. Régistrar's Signature

Year)

2008

31. Date filed (Month,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number, or Location of Death County of Death 14)N 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) New York Months Days Hours 1 M 2 F Yrs 16,1927 April 80 058-24-6371 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland | Anne Arundel Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 U.S.A. 538 Shipley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 1 0 / 5 = 1 0 / Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give 1945 – 1947 Year or Dates 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Elementary/Secondary (0-12) College (1-4or 5+) Department of Agric. 5+ <u>Parasitologist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diamanto Minakakis William Douvres 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5<u>38 Shipley Road</u> Maryland 21090 Angelica V. Douvres Wife Linthicum. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2008 Woodlawn -Maryland 5 ☐ Other (Specify) Greek Cemetery 4 Donation 21. Si majur 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 2 🗆 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ □ 6 24a. Was an autopsy

**Physician** /Medical **Examiner** 

**Physician** /Medical

Examiner

10a, State

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once.

Baltimore, Maryland 21215-0036

be notified

Director

Funeral

by

Completed

æ

ဥ

the Maryland

Examine Physician/Medical þ Be Completed

Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Phones alter death. Funeral Director: After this certificate has been signed by the attending physician and

To the Hospital of within 24 hours at To the Funeral E

Division or Vital Records, P.O. Box 68760.

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant ned by the atter e detached for u in the past 12 months? 9 ☐ Unknown 25. Was case referred to medical examiner? 200 1 ☐ Yes Certification: To 27. Manner of Death Natural
2 Accident 5 ☐ Pending investigation filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 29a. Certifier Medical

29b. Signature and title of certifier

1 patient 2 ER/Outpatient 28a. Date of Injury 28b. Time of

(Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1□ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe

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2008

State Registrar

3□ DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02615 State of Maryland / Department of Health and Mental Hygiene Amy Ferguson 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 2, 2008 2225 hrs **Medical Examiner** Amy Lynette Ferguson c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Fallston 2111 Bellvale Avenue If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 12/09/1978 565-65-0204 Director 29 Country) 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No Laquna Niquel or items 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho
injury or other trannaftic event, the Medical Examiner must be notified at once. CA Orange Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 92677 24596 Camden 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Specify 3 Widowed 4 X Divorced f Yes Give Year 3 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Foodservice Waitress 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Treasa Lee Cusack Jeffrey Lynn Ferguson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24596 Camden, Laguna Niguel, CA 92677 Treasa Lee Cusack, Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 X Removal from Stat 04/07/2008 Laguna Hills, CA O'Connor Mortuary Donation 5 Other Specify 22. Name and Address of Facility O'Connor Mortuary 21. Signature of Fundral Service Livenses CA 92653 25301 Alicia Parkway, Laguna Hills, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death Medical a Methodope and Alcohol Intexication Immediate Cause (Final disease **⊏**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/16/08 amh X UNPENDED e attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live hirth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown Hinknown signed by the a I be detached fo 23e. Did tobacco use contribute to the cause of death? P.O. I contributing to death but not resulting in the underlying cause given in Part I. δ Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has be death? performed' 2 No page Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury Certification: 1 Natural Yes 2 X No Pending 4/2/08 To the Funeral Director: completely filled in by the Unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 111 Bellvale Ave.Fallston MD determined (Specify) Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 3, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner <sup>′ea</sup>2008 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** MARIE **GLADYS** FORWOOD 08 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death TRURS GRALE AR Homz If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 □ F 233-22-8127 Director 87 28, 1920 West Virginia Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 613 High Plain Drive 21014 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☑ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be in Department of Health and Mental Important: If item 27 is marked o Fred Virgil Christian Vinella (nmn) Blair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 High Plain Drive, Bel Air, Maryland 21009
se of Disposition (Name of Date 20c. Location - City or Town, State Tobie L. Jacobs / Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-10-08 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 ns.if rt caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and each line. Approximate Interval Between Onset and Death art1. Enter the disease, or complic shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) ration Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed this certificate Viital 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA P 1 ☐ Inpatient Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Winsen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) — Graums 210'7 & Graums 210'7 &

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 1 2008

. Registrar's Signature

Please Type or Print in Black Indelible Ink amend Item 17 per fh 881 7-11-08 State of Maryland / Department of He AMEND THE #4a, per HES. 1982 Ensure All Copies Are Legible. **3 vt** ealth and Mental Hygiene 2 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 06 3:40a.M Anthony Felder 04 Jerrence Ray /Medical 4a. Facility Name (If not institution, give street and number)
Richey
Joseph Rickey Hospice 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Hours Days Director 218-02-3628 MD 07 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hyglene.
ant: If Item 77 is marked other than "natural", or items 23a or 28a-f show ant: If Item 77 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21239 U.S.A. 1812 Crestview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates: X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) mentary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade 17. Father's Name (First, Middle, Last) Unknow 18. Mother's Name (First, Middle, Maiden Surname) Unknown ٩ Maria Funderburk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great-Grandmother Funderburk 1812 Crestview Road, Baltimore, Md 21239 Mildred Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/12/08 Randallstown, 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee 21215 Baltimore, nt1. Enter the disease, or complications that lock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: use a If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) detached 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe , page certificate Vital 1□ Yes 2 **Z** No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only ope examiner? 20 No Other: 4 Nursing Home 1 ☐ Yeş 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 PResidence 6 □Other (Specify) Certification: To 0 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not b 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Da ame and address ause of death (Item 23a) (Type, Privit State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖖 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician April 8, Jay Hugh Griffey 2008 3:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bel Air Bel All

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Pay, Year | Min. | Month, Pay, Year | May 19, 1913 | Virginia 2935 Lochary Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **3**M 2 □ F 224-01-7722 94 Yrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 28a-f show r than "natural", or Itame 23a or 28a-f shov the Medical Examiner must be notified at Bel Air 1 Yes 2 No Maryland Harford Co. Completed by Funeral Director 10g. Citizen of What Country?
United States 10f. Zip Code 21015 10e. Street and Number 2935 Lochary Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXXo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 3 N/A Laborer Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental H tent: if item 27 is marked other. Ruthie Jae Tussel Henry Riley Griffey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tra 2931 Lochary Road, Bel Air, Maryland 21050 Mrs. Hazel Ellis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Bel Air, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/2008 permit. Page Department of Importent: if any njury or ance. Bel Air Mem. Gdns 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 3 Newport Drive, Forest Hill, Maryland 21015 eh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DEGISE Pnysician OVER 10470 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CEREBRAL THROMBOSIS OVER 10 Y Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine DIAGNIES MELLITUS or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, OVER 104EAR Completed by Physician/Medical ARTHRITIS phys the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ULCERS 1 Yes 2 No 3 Probably 4 Unknown HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 🗌 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

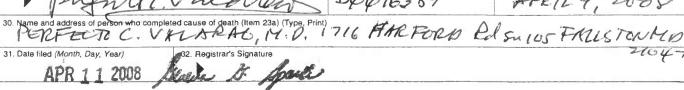
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of dertifier



**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

|                                |   |                          | 1 - State of Maryland / Departm  | nent of Health and M<br>cate of Death                             |                               | giene 2008<br>Reg. No.                      | 11837  |
|--------------------------------|---|--------------------------|--|---|-------------------------------|---|--|
|                                | Physici   | an                       | Decedent's Name (First, Middle, Last)  |   | 2. Date of Dea<br>Month       | Dav Year                                    | 3. Time of Deeth                                 |
|                                | /Medi   |                          | Phyllis Ann Gauger   |   | April                         | 10, 2008                                    | 12:50 P.M  |
|                                | Examir  | er                       | 4a. Facility Name (If not institution, give street and number)  Gilchrist Hospice  | City, Town, or Location of Death TOWSON                           |                               | 4c. County of Deat                          |  |
|                                | Francis   |                          | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If U   | Under 1 Year   If Under 24 Hrs.                                   | 8. Date of Birt<br>(Month, Da |   | hplace (State or Foreign                         |
|                                | Funeral<br>Director   |                          | 215-30-3540 1 M 2 F 73 Yrs. Mor  | nths Days Hours Min.  | (Month, Da<br>May 06,         | y, Year) Co<br>1934 Balt                    | untry)<br>Limore, MD.                            |
|                                | pu ,  |                          | Usual Residence of Decedent  |   |                               |   | 10d. Inside City Limits                          |
|                                | laryla<br>shov  | ē                        | 10a. State   10b. County   10c. City, Town or Location   Maryland   Baltimore County   Baltimore   | ı   |                               |   | 1 ☐ Yes 2 No                                     |
|                                | the N<br>28a-f  | Funeral Director         | -  | f. Zip Code   |                               | 10g. Citizen of What Co                     | untry?   |
|                                | 3a or   | Ö                        | 5924 Daybreak Terr.  | 21206   |                               | United Stat                                 | ces  |
|                                | death   | ner                      |  | Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto | ecify Yes or No-              |   | rican Indian,                                    |
| 36                             | after<br>or Ite   |                          | 1 Never Married 2 Married 1 Yes 2 No   | es 2 (ZNo Specify:  | r nouri, oto.)                | 50  | white  |
| ő                              | hours<br>tural";  | ed by                    | 3 Widowed 4 Landivorced Year or Dates:   | Usual Occupation  |                               | 16b. Kind of Business/                      |  |
| -5                             | in 72<br>"nat   | plete                    | (Specify only highest grade completed) (Give kind of life, DO NO   | of work done during most of work<br>OT use retired)               | ing                           |   | Blue Shield                                      |
| 212                            | d with<br>giene<br>or tha   | E                        | Elementary/Secondary (0-12) College (1-4or 5+) n/a Ma  | il Clerk  |                               |   |  |
| pu                             | e filec<br>al Hy<br>I othe<br>went,   | Be Completed             | 17. Father's Name (First, Middle, Last)  |   | •                             | Maiden Surname)                             |  |
| yla                            | Meni<br>Meni<br>Marked  | ၉                        | Thomas Edward Warner   | Helen Eli   |                               |   |  |
| Mar                            | 12 sho<br>h and<br>7 Is m<br>traum  |                          |  | dress <i>(Street and Number or Rur</i><br>Lybreak Terr.           |                               | er, City or Town, State, 2<br>ore, Maryland |  |
| e,                             | 1 and<br>Healt<br>em 2  |                          | 20a. Method of Disposition  20b. Place of Disposition cemetery, crematory  |   |                               | 20c. Location - City or                     |  |
| Jou                            | ages<br>ent of<br>it: If It<br>y or c   |                          | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funer   | 1 - 200   |                               | Forest Hill                                 | Maruland   |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.       |                          | 4  | ne and Address of Facility<br>Seful Alternativ                    |                               |   |  |
| ñ                              | ang ang ang ang ang ang ang ang ang ang   |                          | Jeffrey J. gars, Rr. 232   | 25 York Road 7  | imonium                       | raractemat.<br>naryland                     | 21093_   |
|                                |   |                          | 23a. P. n.1 Enter the dise pri, or complexitions that clused the death. Do not enter the shock, it heart failure. List only one cause on ach line. | mode of dying, such as cardiac                                    | or respiratory a              | rest,                                       | Approximate<br>Interval Between                  |
| 4                              | Physician   | Ш                        | Immediate Cau (Final disease or condition  |   |                               |   | Onset and Death                                  |
|                                | /Medical<br>Examiner  |                          | resulting in death)  Due to (or as a consequence of):  |   |                               |   |  |
|                                | Lxammer   | <u>.</u>                 | Sequentially list conditions, if any, leading to immediate b   |   |                               |   |  |
| M.                             | uted<br>d<br>insit  | Examiner                 | Cause (Disease or injury   |   |                               |   |  |
|                                | exect<br>an and<br>ial-tra  |                          | that initiated events c  | _   |                               |   |  |
| 8760,                          | Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit | dical                    | d  |   |                               |   |  |
| 9                              | ing ph  | Med                      | IF FEMALE:   |   |                               |   |  |
| Box                            | eath certifii<br>attending<br>for use as  | Physician/Mec            | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto                             | opic pregnancy  |                               | 23d. Date of de<br>Month                    | livery<br>Day Year                               |
|                                | at the de<br>by the a<br>tached f   | ysic                     | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown   | er (specify)  |                               |   |  |
| , P.O                          | res that t<br>signed by<br>be detac   |                          | Part II. Other significant conditions contributing to death but not resulting in the underly   | ring cause given in Part I.                                       | 23e. Did to                   | obacco use contribute to                    | the cause of death?                              |
| rds                            | quires<br>in sign   | D D                      | Breast Concer Sleep Aprila   | Syndrome  | 101                           | res 2 No 3 P                                | robably 4 🗌 Unknown                              |
| Division of Vital Records,     | law requir<br>as been s<br>2 should   | Completed by             | 1 1/1 2  | •   | 24a. Was                      | an 24b. Were au                             | utopsy findings available completion of cause of |
| R                              | The lay   | E O                      |  |   | autop<br>perfo<br>1 □ Yes     | rmed2   death?                              | _  |
| ita                            | siclan: The<br>certificate<br>rector, pag   | Be C                     | 25. Was case referred to medical examiner?   | 26. Place of Deat   |                               | · · · · · · · · · · · · · · · · · · ·       | - 11   |
| of V                           | Physic<br>this or<br>al dire  |                          | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐   |   |                               | dence 6 Other (Spe                          | city) to spice                                   |
| n c                            | ding F  | ië                       | 27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  S S S S S S S S S S S S S S S S S S S   | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                         | 28d. Describe I               | now injury occurred                         |  |
| isio                           | death<br>ctor:<br>y the   | licat                    | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa  |   | 28f. Location (5              | Street and Number or R                      | ural Route Number.                               |
| Οį                             | after<br>after<br>Direction by  | erti                     | 4 Homicide determined building, etc. (Specify)   | ,   | City or Tov                   |   |  |
|                                | pspita<br>hours<br>ineral   | edical Certification: To | 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investig   | At the second second  | 1 1 11 11                     |   |  |
|                                | To the Hospital or Attend within 24 hours after death To the Funeral Director; , completely filled in by the f  | edic                     | one) and manner stated.  | т   | red at the time,              | uate and place, and out                     | = to the cause(s)                                |
|                                | or To The Top   | Σ                        | 29b. Signature and title of certifier  | 29c. License number   |                               | 29d. Date signed (Mont                      | th, Day, Year)                                   |
|                                |   |                          | 17/ Holly hand   | 1) 25 205   |                               | H/11 10,                                    | 2003   |
| L.                             | 10  |                          | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | ale St Ral  | to .                          | MJ 2121                                     | x  |
|                                | Sta   | ite                      | 31. Date filed (Month, Day, Year) 32 Registrar's Signature   | 29c. License number  0°25205  Cula St Bal                         | -1 - /                        |   |  |
|                                | Regist  | - 1                      | APR 1 1 2008 Source St Specific  |   |                               |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 7:28 P M April 9, 2008 Lydia R. Gonzalez /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Cockevsville Lorian Nursing Home Mays Chapel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 K F Months 92 Puerto Rico 05/05/1915 070-16-6394 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County a or 28a-f show be notified at 1 ☐ Yes 2 X No Timonium MD Baltimore Director the ! 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21093 ns 23a c must be 25 Crotona Court Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: /white ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked α
 er traumatic eve Margot Pietrantoni Lee Bolton Rever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 David Luther Ct. Cockeysville, MD 21030 Ernesto Gonzalez, III Department of Health Important: If item 27 any injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 04/11/2008 Towson, Md Hilltop Serv. Corp. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Enneral Service Licensee Ruck Towson Funeral Home 1050 York Rd Towson, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Interioscleratic Caedinascula Physician eas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe res 2 death? 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated

ID

31. Date filed (Month, Day,

30. Name and address of person who completed cause

29b. Signature and title of certifier

2008



of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 **Physician** April 9. 12:15 P M Francis Xavier Gibbons /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner P.O.Box 392 Glen Arm Baltimore 1 Gunpowder Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/17/1930 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1**X** M 2 □ F 214-26-2821 77 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director MD Baltimore Glen Arm 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number P.O.Box 392 USA 21057 1 Gunpowder Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1xXYes 2 No If Yes, Give Year or Dates: 1947–51 1 Never Married 2 Married 1 ☐ Yes 2XXNo 3altimore, Maryland 21215-0036 Specify. White <u>ک</u> 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Drvden Oil Co. Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( John Joseph Gibbons Helena Latleif 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Gunpowder Road P.O.Box 392 Glen Arm, MD 21057 Barbara M. Gibbons / Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cem. 4/15/2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21. Signature of Funeral Service Li 21204 Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART YEARS **Physician** /Medical Due to (or as a consequence of): CONWARY VASCULAR PURASE **Examiner** ATHEROSCIPPOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): burialattending physician for use as the burlal Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Pulmonnom OBSTWUTUE 1 Yes 2 No Completed 24a. Was an

Division or Vital Records, P.O. Box 68760, funeral director, After this Director: /

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 4/10/08 00047625

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 OSLER DRIVE, SUIKE 311. TOWSON, MO 21204 OMALLEY MO 31. Date filed (Month, Day, Year)

Registrar

Be

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Certification:

Medical

24 hours a

Please Type or Brint in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:02P M APRIL 2008 ALAN GREENBLATT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BLAKEHURST HEALTH CENTER TOWSON **BALTIMORE** 6. Sex 1 M 2 □ F Date of Birth (Month, Day, Year) 03/27/1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 217-18-8003 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show must be notified at 1 ☐ Yes 2 No Funeral Director BALTIMORE PIKESVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 8004 STEVENSON ROAD items 23a 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, Ite Medical Examina-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE 5+ BROKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES GREENBLATT ROSE GREENFIELD ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 STEVENSON ROAD, PIKESVILLE, MD MARY GREENBLATT / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 ☐ Removal from State TOWSON, MD HILLTOP SERVICE CORP. 04/<del>10</del>/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) s been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: this c 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death
12 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

35

State Registrar celle

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

N Charles St, Balthrore MD 21212

who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LOUIS HARRY GOLDSTEIN APRIL 08 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** BALTIMORE HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07/29/1931 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) tient also known as Louis GOLDSTEIN
Baltimore, Maryland 21215-0036 **Funeral** 171-26-3596 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 GRISTMILL COURT, APT. 105 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 □ No NAVY If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) VICE PRESIDENT OF PURCHASING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOLDSTEIN ADA SAMUEL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONA GOLDSTEIN / WIFE 1 GRISTMILL COURT, APT. 105, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH ISRAEL 04/10/2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MY ELOGENOUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an certificate in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA i or Attending Plater death.

i Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

14. Race - American Indian Black, White, etc. WHITE Specify: 16b. Kind of Business/Industry FOOD DISTRIBUTOR SLIPAKOFF 20c. Location - City or Town, State COATESVILLE, PA SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 1 month 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) RES 000 APRIL, 8, 2008 BELVEDEKE AVE , SINAI HOSPITAL OF BALTIMORE, 2401 WEST BALTIMORE MD

Reg. No.

Day

Year

2008

4c. County of Death

USA

N/A

07: 45 AM

Birthplace (State or Foreign Country)
 D A

PA

10d. Inside City Limits

1 ☐ Yes 2 No

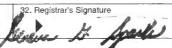
State Registrar

TALWAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 11:35 AM Licien King Harris 8, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 Months Days Hours Min. 89 Director 10/04/1918 578-10-4334 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "motical Experience result to rectified at 1 Yes 2 □ No **Funeral Director** MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1309 John Street 21217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Graphic Elementary/Secondary (0-12) College (1-4or 5+) Fashion Illustrator Designer/Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Louis S. King Esther Bergner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Elizabeth Harris/Daughter 331 Sherman Street Longmont, CO 80501 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ò permit. Page Department o Important: If any Injury or once. Apr 10 4 ☐ Donation 5 ☐ Other (Specify) 2008 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cremation and Funeral Alternatives Maryland Approximate Interval Between Onset and Death SUBARACHNOID Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TRIP AND Esquerdiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed OUMADIN physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical FIBRILLATION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 MNo
9 Unknown Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause g e n Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1000 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No TRIP AND FALL IN BATH LOOM death. MARCH 27, 2008 UNKNOWN ours after death.

neral Director: A
filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Home 1309 JOHN STREET, BALTIMORE, M.B. To the Hospital within 24 hours a To the Funeral E 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL8, 2008 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE, MD 21204 6565 N CHAPLES ST, SMIR 209 DANIEUE DOBERMANIMO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 1 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

of Vital

Division

|             |  |                | 1 - For state amend #22   | Per             | State of FH G8                          | f8 <sup>Maryla</sup>                         | 1/08 <sup>[</sup>      | Dena<br>Cen           | rtment of I  | Health<br><i>Death</i>     | and M                    | lental Hy                         | /giene<br>Reg. No.       | 2008  | 11843  |
|-------------|--|----------------|---|-----------------|---|--|------------------------|-----------------------|--|----------------------------|--------------------------|-----------------------------------|--------------------------|---|--|
| -           | H ,  | -63            | 1. Decedent's Name (First, Middle                                       | e, Last,        | )                                       |  |                        |                       |  |                            |                          | 2. Date of D                      |                          |   | 3. Time of Death                                   |
|             | Physic   |                | Christion A   | lber            | rt Ha                                   | rris   |                        |                       |  |                            |                          | April                             | . Bay                    | 20 <sup>4</sup> 08                              | 4:29 PM  |
|             | /Medi<br>Examir  |                | 4a. Facility Name (If not institution                                   |                 |   |  |                        |                       | 4b. City, Town,  | or Location                | of Death                 |                                   | 4c.                      | County of Deatl                                 | h  |
|             |  |                | Greater Balt  | imo             | re Me                                   | dical  | Cer                    | n t e                 | r Tows   | on                         |                          |                                   | F                        | Baltim  | ore  |
|             | Funeral  |                | 5. Social Security Number   | 6. Se:          | K                                       | 7. Age (In yi                                |                        |                       | ff Under 1 Year  | If Unde                    |                          | 8. Date of Bi<br>(Month, D        |                          | 9. Birth  | nplece (State or Foreign                           |
| e a company | Director   |                | None  | 1 🛭             | ØM 2□F                                  |  |                        | Yrs.                  | Months Days  | Hours                      | Min.                     | April                             |                          |   | untry) MD  |
| -           | D.   |                | Usual Residence of Decedent   |                 |   |  |                        |                       |  |                            |                          |                                   |                          |   |  |
|             | show   |                | 10a. State 10b. County  |                 |   | 10c.   | City, Town             | n or Loc              | ation  |                            |                          |                                   |                          |   | 10d. Inside City Limits                            |
|             | W - W  | cto            | MD  |                 |   | Ba   | altim                  | ore                   | City   |                            |                          |                                   |                          |   | 19€ Yes 2 No                                       |
|             | e e ∃  | Director       | 10e. Street and Number  |                 |   |  |                        |                       | 10f. Zip Code  |                            |                          |                                   | 10g. Citi                | zen of What Co                                  | untry?   |
|             | d within 72 hours after death with the Maryland plene. r then "natural", or Items 23a or 28e-f show then "natural" sa chiner must be notified at the Medical Exantiner must be notified at   |                | 5565 Midwood Av   | /enu            | ie                                      |  |                        |                       | 21212  |                            |                          |                                   | US                       |   |  |
|             | er de  | Funerai        | 11. Maritaf Status  |                 | <ol><li>Was Dece<br/>Armed Fo</li></ol> |  | U.S.                   | 13. W                 | as Decedent of<br>Yes, specify Cub                       | Hispanic O<br>an, Mexica   | rigin? (Sp<br>ın, Puerto | ecify Yes or N<br>Rican, etc.)    | 0-                       | <ol> <li>Race - Ame<br/>Black, White</li> </ol> |  |
| 36          | or it  | by Fu          | 1 Never Married 2 Mar   |                 | 1 ☐ Yes<br>ff Yes, Giv                  | /0   |                        | 1                     | ☐ Yes 21 No  | Specify                    | <i>r</i> :               |                                   |                          | Specify:  |  |
| 8           | ural   | d b            | 3 Widowed 4 Divorced  | -               | Year or D                               | ates:  | 1 40-                  | 0                     |  |                            |                          |                                   | 1 404 16                 |   | ack  |
| ιĠ          | nat  | Completed      | 15. Deceder<br>(Specify only highs                                      |                 |   |  | 168.                   | (Give k               | ent's Usual Occu<br>and of work done<br>O NOT use retire | durina mo                  | st of work               | ing                               | 16b. Kii                 | nd of Business/                                 | industry   |
| 12          | within<br>ene.<br>then   | Ę.             | Elementary/Secondary (0-12)   | İ               | College (1                              | 1-4or 5+)                                    |                        |                       |  | .07                        |                          |                                   |                          |   |  |
|             | Hygie<br>Hygie<br>ther<br>ant,   |                | 17. Father's Name (First, Middle,                                       | Last)           | 0                                       |  |                        |                       | Infant   | 18. Moth                   | er's Name                | e (First, Middle                  |                          | Infant<br>Sumame)                               |  |
| an          | ould be filed with<br>Mental Hygiene.<br>arkad other the<br>atic event, Itali  | Be c           | H .   | ŕ               |   |  | 77                     |                       |  |                            | _                        |                                   |                          |   | _  |
| Maryland    | ges 1 and 2 should be filed<br>it of Health and Mental Hygi<br>If item 27 is merked other<br>or other traumatic event, I   | 은              | Robert  19a. Informant's Name/Relations                                 | hin (Tu         | roe Print)                              |  | Harr                   |                       | Address (Stree   |                            | arla                     | al Route Numl                     | her City o               |   | arris<br>Tip Code)                                 |
| Ma          | d 2 s<br>th an<br>7 is<br>trau   |                | 6-BMC Porin   |                 | <i>y</i>                                |  | (J                     |                       | VILLA  | RIKC                       | 5                        | Tolal                             | 1 2/                     | M =13   | TKL  |
|             | 1 and 2<br>Health<br>em 27<br>ther tra   |                | 20a. Method of Disposition  | VUC             |   | 206  | . Place of             | Dispos                | ition (Name of   |                            |                          | Date                              | 20c. Lo                  | cation - City or                                | Town, State  |
| و           | Pages<br>nent of I<br>nt: If it  |                | 1 🗆 Burial 2 😿 Cremation  |                 | Removal from                            | State  | cemeter                | ry, crem              | atory or other pla                                       | (08)                       | 04/1                     | Jane                              | 0                        | - /-  | y ma   |
|             |  |                | * 4 □Donation 5 □ Other (S<br>21. Signature of Furperal Service         |                 |   | (-)  |                        | 100                   | U CAPY   | you                        | 0)//                     | 1/2001                            |                          | LD OT   | //.  |
| Ba          | permit. Departm Importe any inju   |                | I signature of running service  | Liceris         | redi                                    | -  |                        | 22.                   | Name and Addr  |                            |                          | _                                 |                          | onkton,   | Company<br>MD 21111                                |
| 100         |  |                | 23a. Part1. Enter the disease, o shock, or heart failure. List          | compl<br>only o | ications that c<br>ne cause on e        | aused the de<br>ach line.                    | eath. Dor              | not ente              | r the mode of dy   | ng, such as                | s cardiac                | or respiratory                    | arrest,                  |   | Approximate<br>Interval Between<br>Onset and Death |
| F           | Physician  |                | Immediate Cause (Final disease or condition                             |                 | EX                                      | other  | ne                     | 1                     | rem  | ato                        | u't                      | 7                                 |                          |   | Oliset and Death                                   |
|             | /Medical<br>Examiner   |                | resulting in death)   |                 | Due to (                                | or as a cons                                 | equence                | of):                  |  |                            |                          |                                   |                          |   |  |
|             | Examine  |                | Sequentially list conditions,   |                 | o                                       |  |                        |                       |  |                            |                          | `                                 |                          |   |  |
|             | p ii   | ine            | if any, leading to immediate cause. Enter Underlying                    | Į –             | Due to                                  | or as a cons                                 | eque ice               | oty.                  |  |                            |                          |                                   |                          |   |  |
|             | sician and<br>burial-transit   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last |                 | o.<br>Dua ta /                          | or as a cons                                 | 0.000000               | of):                  |  |                            |                          |                                   |                          |   |  |
| 90,         | oe ex<br>cian<br>cian  |                | ,,,,,   |                 | Due to (                                | or as a cons                                 | ednerice               | OI).                  |  |                            |                          |                                   |                          |   |  |
| 8760        | cate be exphysician  | dicai          |   |                 | d                                       |  |                        |                       |  |                            |                          |                                   |                          |   |  |
| 9           | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit   | Me             | IF FEMALE:  |                 | 0                                       |  |                        |                       |  |                            |                          |                                   |                          |   |  |
| Вох         | ath cert<br>attendin<br>for use  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                       | 2               |   | irth 2 🗆 F                                   | etef death             |                       | Ectopic pregnanc   | У                          |                          |                                   | 2                        | 23d. Date of deli<br>Month                      | ivery<br>Day Year                                  |
| 0           | the a  | /sic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                 | 4∐Pregn<br>9∐Unkno                      | ant at time o                                | death                  | 5 🗌                   | Other (specify) _  |                            |                          |                                   |                          |   | ,  |
| <u>G</u>    | requires that the digen signed by the hould be detached  | Phy            | Part II. Other significant conditi                                      |                 | nterbruting to de                       | andb but not a                               |                        |                       | d k . i  | one in Dank                |                          | age Did                           | toboooo                  | na anatributa ta                                | the cause of death?                                |
| S,          | 8 E 8  | þ              | Partin. Other significant conditi                                       | JIIS COI        | ithouting to de                         | satir but not r                              | ezumig ii              | i meruna              | uenying cause gr   | venimran                   | 1,                       |                                   |                          |   | obably 4 DUnknown                                  |
| Record      | w requir<br>been si<br>shoutd  | Completed      |   |                 |   |  |                        |                       |  |                            |                          |                                   | Yes 2                    |   | ——————————————————————————————————————             |
| 0           | s b  | pie            |   |                 |   |  |                        |                       |  |                            |                          | 24a. Was                          | s an<br>opsy             | prior to d                                      | topsy findings available<br>completion of cause of |
|             | ate<br>pag   | No.            |   |                 |   |  |                        |                       |  |                            |                          | perf<br>1 ☐ Yes                   | ormed?                   | death?  | 2□ No  |
| Vital       | ysician: Th<br>is certificate<br>director, pag   | Be (           | 25. Was case referred to medica examiner?                               |                 |   |  |                        |                       |  | 26. Plac                   | e of Deat                | h (Check only                     | one)                     |   |  |
| of V        | d is   | 10             | 1 ☐ Yes 2 ☐ No  |                 | lospital:                               | npatient 2                                   | □ ER/Ou                | tpatient              | 3□ DOA Ot  | her: 4□N                   | ursing Ho                | me 5 🗆 Res                        | idence 6                 | 3 □Other (Spec                                  | cify)  |
|             |  |                | 27. Manner of Death 1 XNatural 5 ☐ Pendir                               | na              | 28a. Date (<br>(Mont                    | of Injury<br>th, Day Year)                   | 28b. 1                 | Time of njury         | 28c. Inju  | ry at                      |                          | 28d. Describe                     | how injur                | y occurred                                      |  |
| <u>Ö</u>    | Attending<br>r death.<br>ector: Afte<br>by the fune  | atic           | 2 ☐ Accident investi  | gation          |   |  |                        |                       | M 1  | Yes 2                      | ]No                      |                                   |                          |   |  |
|             | or Attendation of the Control of the | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                            |                 | 28e. Pface<br>buildii                   | of Injury - At                               | t home, fa             | rm, stre              | et, factory, office                                      |                            |                          | 28f. Location<br>City or To       | (Street and              | d Number or Ru<br>)                             | iral Route Number,                                 |
|             | rs aff   | Š              |   |                 |   |  |                        |                       |  |                            |                          |                                   |                          |   |  |
|             | To the Hospital or Attenwithin 24 hours after deatl To the Funaral Director: completely filled in by the   | Medicai        | 29a. Certifier 1 Certifyin<br>(Check only one) 2 Medical                | g Phy<br>Exami  | ner: On the ba                          | best of my k<br>asis of exami<br>ner stated. | nowledge<br>ination an | e, death<br>d/or inve | occurred at the t<br>estigation, in my                   | ime, date a<br>opinion, de | nd place,<br>ath occur   | and due to the<br>red at the time | e cause(s)<br>, date and | and manner as<br>place, and due                 | stated.<br>to the cause(s)                         |
|             | within<br>To the<br>comple   | M              | 29b. Signatyre and title of certifie                                    | r               |   | ~  |                        |                       | 29c. Licen   | se number                  |                          |                                   | 29d. Dat                 | e signed (Montl                                 | h, Day, Year)                                      |
|             |  |                | Do W  | \/              |   |  |                        |                       | D391   | 70                         |                          | ,                                 | Ann                      | i1 00   | 2008   |
|             | MP.  |                | 30. Name and address of person  | who a           | mpleted caus                            | e of death (I                                | tem 23a) (             | (Type, P              |  | 12.                        |                          |                                   | _ Apr                    | il 08,  | 2006   |
|             |  |                | Ginny Merryman  | , M             | _                                       |  | 59 N.                  |                       | arles St   | #50                        | TO                       | wson. M                           | 4D 21                    | 204   |  |
|             | Sta  | ate            | 31. Date filed (Month, Day, Year)                                       |                 | 32. R                                   | wistrar's Sig                                | nature                 | — <del>      </del>   | LES ST   | + +36                      | <u> </u>                 |                                   | +4/ C. <u>1</u>          | <u> </u>  |  |
|             | Regist   | rar            | APR 1   | 12              | 008                                     | Halisa.                                      | J.                     | 19                    |  |                            |                          |                                   |                          |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 250 Month Year **Physician** 2008 Ori /Medical not institution, give street and number, 4c. County of Dea 4b. City, Town, or Location of Death Examiner N/ more If Under 24 Hrs. Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219.26. 634 1 ☐ M 2 💢 F Months Hours NC 69 Yrs. Director 03/28 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits ns 23a or 28a-f show Baltimore Randallstow 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 8628 Windmill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) is 1 and 2 should be filed within 72 hours after deal of Health and Mental Hygiene.
Item 27 is marked other then "natural", or Items other treumatic event, the Medical Examinar mu 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security College (1-4or 5+) Elementary/Secondary (0-12) Supervisor 4aministration 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -daar Hughes Inomas 19a. Inf ant's Name/Re nship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Wesley J. Hughes Street Baltimore MD 21231 122 S. Broadway 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dissition Date permit. Pages 1
Department of H
Important: If Ite
ony injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Momorial Dark 0415/08 Wirdsor Mill, MD Vaughn C. Breene Funeral Sovices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7 MO 1363 8728 Liberty Road Randall stown MD 21/33 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) 10min **Physician** Kespirato /Medical Due to (or as a consequence of): Examiner Myocar dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA ပ 1 Inpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intury occurred Certification: 5 Pending investigation 1 Matural death. 2 Accident 6 Could not be determined 3 Suicide Ptace of tniury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funaral Direct 4 | Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the Ë 29b. Signatury and title of certifier 29d. Date signed (Month, Day, Year) DO063128 argine 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Sargine Brutus MD 900 S. caton Ave Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

APR 1 1 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📋 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BERNICE 9:03 PM MARV JONES Apri 8 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital 06 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2**X** F Months Days Hours 213-24-6136 Director 88 12/17/1919 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Baltimore Director Md. with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 Bayonne Avenue U.S.A. 14. Race - American Indian, 21214 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black ģ 3 Widowed 4 □ Divorced

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

Embolisa

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pulmonary
Due to (or as a consequence of):

Probation Officer

(Give kind of work done during most of working life. DO NOT use retired)

Crownsville VA Ceme. 04/14/2008

16b. Kind of Business/Industry

Law Enforcement

20c. Location - City or Town, State

Crownsville, Maryland

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility The Derrick C. Jones F/H, P.A.

4611 Park Hgts. Ave., Baltimore, Maryland 21215

Lettie Ball

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Bayonne Ave., Baltimore, Maryland 21214

**Physician** /Medical Examiner

the death certificate be executed

Box 68760.

P.O. |

Division or Vital Records,

12 should be filed within 7 and Mental Hygiene.

. Pages 1 and 2 should be fill trent of Health and Mental H tant: If item 27 is marked oth

Completed

Be

၉

15. Decedent's Education (Specify only highest grade completed)

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Hansen

APR 1

31. Date filed (Month, Day, Year)

College (1-4or 5+)

Elementary/Secondary (0-12)

Ben Cecil

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Robert McKinney / Son

21 Signature of Funeral Service Licensee

Examine the attending physician and ned for use as the burial-tran Physician/Medical ast signed by the a 2 Completed After this certificate has funeral director, Be P Certification: To the Hospital or Attendit within 24 hours after death.

To the Funeral Director; Al completely filled in by the fu

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universaled in injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59062 April 9 2008 7.0.

DHMH 17 Rev 1/2001

Registrar

2401 W Belvedere

32., Registrar's Signature

Baltimore

MO 2/2/5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend #26 Per Phy G878 4/11/08 THE art of Death

Registrar

Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month April 9 2008 4:33 A M /Medical IRIS ANN JACKSON 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 413 Latimer Road Joppa Harford 5. Social Security Number 6 Sex it Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthdav) Months Hours 1 □ M 2 1 T F Director 577-42-7887 76 10, 1931 Washington, Dec. DC Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show iral" or items 23a or 28a-f show Exeminer must be notified at Director TYES 2 No Maryland Harford 120 Archer Street 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 120 Archer Street 21014 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ound 2 shoul( be filed within 72 hours after the Health and Mental Hygiene.
9m 27 is marked out. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Samuel E. Davis Julia Elizabeth Wright ဂ္ other traumatie Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Mitchell / Daughter 7805 Bennerton Dr., Baltimore, Maryland 21236 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Injury o 5 Other (Specify) 4 Donation Hilltop Service Corp. 4-10-08 Towson, Maryland 21. Signature of eral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cell L Physician Cancer Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only open 1 ☐ Yes 2 No Other: 4 Nursing Home Daughter's Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Li Residence 6 Mother (Specify) Residence 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Checone) 29b. Signat nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Pript)

WO Min (M.O.) GOZ South Atwood Road #200 31. Date filed (Month, Day, Year) 32. gistrar's Signature State APR 11 2008 Registrar

DHMH 17 Rev 1/2001

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN THE PLANT OF THE PROPERTY OF

| f <sub>2</sub> |  |                  | For State Of IV  State Registrar  1. Decedent's Name (First, Middle, Last)   |   | ertificate of Death  | , ,   | 9. No. 2 0 0 0   | 3. Time of Death                      |
|----------------|--|------------------|--|---|--|---|--|---------------------------------------|
|                | Physici  |                  | Richard  |   | Jones  | APRIL   | Day Year   | 0545 AM                               |
| ()<br>_g'e=    | /Medio   |                  | 4a. Facility Name (If not institution, give street and number  | -)  | 4b. City, Town, or Location of Deatl   |   | 4c. County of Death                                    | 0242 W                                |
|                |  | Ą                | Northwest Hospital   | •   | Randallstown   |   | Baltimor   | е                                     |
| Į,             | Funeral<br>Director  |                  | 218-28-3363 X M 2 F  | ge (In yrs. last birthda<br>76 Yrs.               | y) if Under 1 Year If Under 24 Hrs. Months Days Hours Min.                                   | 8. Date of Birth (Month, Day, )                 | 9. Birthplac<br>Country                                | ce (State or Foreign ) MD             |
| 1              | and<br>t   |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or                                | Location   |   | 10d.   | . Inside City Limits                  |
| 100            | -fshc  | ţō               | MD NA  | Balti   | more   |   |  | 1 X Yes 2 □ No                        |
| d<br>d         | r 28a  | Director         | 10e. Street and Number   |   | 10f. Zip Code  | 100   | g. Citizen of What Country                             | ?                                     |
| 1              | 23a o<br>Ist be  | al D             | 5741 Edmondson Ave   |   | 21229  |   | U.S.A.   |                                       |
| 7              | er my  | Funeral          | 11. Marital Status 12. Was Decedent Armed Forces   | t Ever in U.S. 13                                 | B. Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puerl              | pecify Yes or No-                               | 14. Race - American<br>Black, White, etc               |                                       |
| 215-0036       | iner which is a nous alter bean with the maryland that Hygiene and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | þ                | 1 ☐ Never Married 2 ☐ Married 1 M Yes 2 ☐ If Yes, Give Year or Dates:  | No  | 1 ☐ Yes 2 No Specify:  |   | 0  | ack                                   |
| o s            | "natu  | ete              | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Dec  | edent's Usual Occupation<br>re kind of work done during most of wor<br>. DO NOT use retired) | rking   | 6b. Kind of Business/Indus                             | stry                                  |
| 121            | than   | Completed        | Elementary/Secondary (0-12) College (1-4or 10th grade na   | 5+1   | rane Operator  | I   | eamship Tr   | ade                                   |
| V 3            | Hygir<br>ther  | ပို              | 17. Father's Name (First, Middle, Last)  |   |  | ne (First, Middle, Ma                           |  |                                       |
| yland<br>yldbe | ked o  | To Be            | Samuel Jones   |   | Marie L  | _   | adon Garnamo,  |                                       |
| a <b>Z</b>     | and Menta<br>Is marked<br>raumatic ev  | -                | 19a. Informant's Name/Relationship (Type. Print)   | 19b. Mai  | lling Address (Street and Number or Ru   | ıral Route Number, (                            | City or Town, State, Zip Co                            | ode)                                  |
| , Mai          | alth a   |                  | Samuel Jones-Son   |   | Scott Street,  |   |  | 230                                   |
| ore            | r of He<br>or oth  |                  | 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State   | 20b. Place of Disposer cemetery, cr               | position (Name of ematory or other place)  | Date 20   | oc. Location - City or Town                            | ı, State                              |
| Baltimor       | rtant:   |                  | 4 Donation 5 ☐ Other (Specify)   | Garris  | on Forest Vet.   | 4/8/08  | Owings Mil   | ls, Md                                |
| ם מ            | permits ages it and a should of permits ages it and want I mportant: If item 27 is marked any injury or other traumatic evonce.  |                  | 21. Signature of Funeral Service Licensee  |   | 22. Name and Address of Facility March F/H West  | Doleie  | mara Ma  | 21215                                 |
|                | GOLA.  |                  | 23a. Part1. Ent. the disease, or complications was cause shock, or heart failure. List only one cause on each i  |   | 4300 Wabash Ave  |   | t. A   | pproximate                            |
| P              | hysician   |                  |  |   |  | ,,  |  | terval Between<br>nset and Death      |
|                | /Medical   |                  | disease or condition resulting in death)  Due to (or as  | a consequence of):                                | CANCER   |   |  |                                       |
| E              | xaminer  |                  | Sequentially list conditions b.  |   |  |   |  |                                       |
| / 7            | is is  | ine              | Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury  | a consequence of):                                |  |   |  |                                       |
| Yequit         | and<br>Il-tran   | хап              | that initiated events c.   | a consequence of):                                |  |   |  |                                       |
| o rou,         | in physician and as the burial-transit   | Aedical Examiner |  |   |  |   |  |                                       |
| ifficate       | g phys   | edic             | d  |   |  |   |  |                                       |
| S P            | anding<br>use a  | M                | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome   |   |  |   | 23d. Date of delivery                                  | DANN'A                                |
| deat           | e atte   | icia             | in the past 12 months?   |   | ☐Ectopic pregnancy ☐ Other (specify)   |   | Month Da   | ay Year                               |
| at the         | signed by the attendir   | Physician/       | 9 ☐ Unknown  |   |  |   |  |                                       |
| v the          | igned<br>be de   | by F             | Part II. Other significant conditions contributing to death b  | out not resulting in the                          | underlying cause given in Part I.  | 23e. Did tobac                                  | cco use contribute to the c                            | cause of death?                       |
| requires       | een s<br>nould   |                  |  |   |  | 1 ☐ Yes   | 2 No 3 Probabl   | ly 4 dnknown                          |
| N N            | as b   | Completed        |  |   |  | 24a. Was an autopsy                             | 24b. Were autopsy                                      | findings available letion of cause of |
| - 4<br>-       | n.<br>After this certificate has<br>funeral director, page 2.3   | Cou              |  |   |  | performe<br>1☐ Yes 2 ☐                          | death?   | □ No                                  |
| V I Le         | certifi  | Be               | 25. Was case referred to medical examiner?  1 Types 2 Types   Hospital: Hospital:  |   |  | th (Check only one)                             |  |                                       |
| Phys           | this ral dir   | ٦.               | 1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐   | <del></del>                                       |  |   | ce 6 ☐Other (Specify)                                  |                                       |
| ding           | h.<br>fune   | tion             | 1  | y Year) Injury                                    | of 28c. Injury at Work?  M 1 □ Yes 2 □ No  | 28d. Describe how                               | injury occurred  |                                       |
| Atten          | deat<br>octor  | fica             | 3 Suicide 6 Could not be 28e. Place of ini   | ury - At home, farm, s                            |  | 28f. Location /Stree                            | et and Number or Rural Ro                              | oute Number                           |
| a o            | after<br>I Dire  | Certification:   | 4 ☐ Homicide determined building, el   | tc. (Specify)                                     |  | City or Town, S                                 | State)   | oute reamper,                         |
| e Hospit       | within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical (        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st   | ot examination and/or i                           | th occurred at the time, date and place<br>nvestigation, in my opinion, death occu           | , and due to the caus<br>rred at the time, date | se(s) and manner as state<br>and place, and due to the | ed.<br>e cause(s)                     |
| #              |  |                  | /  |   |  |   | DoAmini Id (Month Do                                   |                                       |
| 2              | To th<br>comp  | Ž                | 29b. Signature and title of certifier  |   | 29c. License number  | 29d   | . DaApigied (Month, Day                                | v, Year)                              |
| P              | withir<br>To th<br>comp  | W                | 29b. Signature and title of certifier  |   | 1445931  |   | WRIL 2   | y, Year)<br>2008                      |
| 1              | within 7 to the comp   | Me               | 30. Name and address of person who completed cause of completed cause of the complete cause of the cause of the complete cause of the complete cause of the cau | death (Item 23a) (Type                            | 1445931  |   | WRIL 2   | y, Year)<br>2008                      |
| 7              | State Registra   | te               | 30. Name and address of person who completed cause of control of the control of t | leath (Item 23a) (Type<br>25 N<br>rar's Signature | H45931<br>MN STNET RE  |   | WRIL 2   | y, Year)<br>2008                      |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 765 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner saltimore coin 8. Date of Birth (Month, Day, 09 17 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Year) Days Min. 1 □ M 2 🙀 F Yrs 219-18-8425 95 12 Director VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If I fem 27 is marked other than "natural" ~ ... any injury or other traumatic even. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County Yos 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 U.S.A. 2919 Virginia Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Self Employed 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amanda Lewis 0 Clifford Sturtevant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2919 Virginia Ave, Baltimore, Md <u> Kathleen Parker-Niece</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 4/14/08 Randallstown, 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licenses 23a. Party. Enter the disease, or complicitions the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death I nmeriate Cause (Final disc se or condition resulting in death) **Physician** Soleret /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph d for use as th IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 □ No 3 ☐ Probably 4 🗖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed certificate 1∏ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 ☐ Inpatient P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 ☐ Pending Intury M investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 4 Macen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 61 bnir AMA-EM) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

|   |       |                   | For   |                             | State              | of Mary                       |                            | •            | rtment of H  |  | and M       | ental Hy                            | /giene                 | Э                |                               |                         |              |
|---|-------|-------------------|---|-----------------------------|--------------------|-------------------------------|----------------------------|--------------|--|--|-------------|-------------------------------------|------------------------|------------------|-------------------------------|-------------------------|--------------|
|   |       |                   | State Registrar   |                             |                    |                               |                            | Cer          | tificate of L  | Death                                  |             | 0.0.1.70                            | Reg. No                | 20               | 08                            |                         | 849          |
| Phys  | sicia | - 20              | Decedent's Name (First, Mid   | idle, Last)                 |                    |                               | Jeff                       | 2            |  |  |             | 2. Date of D<br>Month               | Da                     |                  | Year                          | 3. Time                 |              |
|   | edica |                   | 4a. Facility Name (If not institu   | tion give st                | reet and n         | ımher)                        | 704                        | < Y S        | 4b. City, Town, or   | Location of                            |             | April                               | 40                     | . County o       | of Death                      | 19:                     | 13           |
| Exar  | mine  | er                | Johns Hopkins   |                             |                    | anno cry                      |                            |              | Baltimore  |  |             |                                     |                        |                  |                               |                         |              |
| Funer   | rai   |                   | 5. Social Security Number   | 6. Sex                      |                    | 7. Age (In                    | yrs. last birth            | day)         | If Under 1 Year Months Days                                      |  |             | 8. Date of Bi<br>(Month, D<br>SEPT. | irth<br>av. Year.      | )                | 9. Birthp                     | place (State            | or Foreign   |
| Direct  | or    | - 1               | 213 76 9939   | X                           | M 2□F              | 4                             | 3 Yr                       | s.           | World 5 Days   | Tiodio                                 | .,,,,,,     | SEPT.                               | 16,                    | 1964             | M                             | Ď´                      |              |
| and w   |       |                   | Usual Residence of Decedent<br>10a. State 10b. Cour   | nty                         |                    | 10                            | c. City, Town o            | or Lo        | cation   |  |             |                                     |                        |                  | 1                             | I0d. Inside             | City Limits  |
| Mary<br>-f sho  |       | ٥                 | MD I  | A/A                         |                    |                               | H                          | 3A.          | LTIMORE  |  |             |                                     |                        |                  |                               | 1 <b>X</b> ∫Ye          | s 2∏No       |
| h the<br>or 28a<br>a notifi   | ß .   | Director          | 10e. Street and Number  |                             |                    |                               |                            |              | 10f. Zip Code  |  |             |                                     | 10g. Ci                | tizen of W       | hat Coul                      | ntry?                   |              |
| th wit<br>23a c<br>ust be   |       |                   | 4801 BOWLAN   | 1D AV                       | Έ.                 |                               |                            |              | 212  | 206                                    |             |                                     |                        | USA              |                               |                         |              |
| ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medicia Examiner must be notified at | 1     | by Funeral        | 11. Marital Status  1 □ Never Married 2 🛣 M  3 □ Widowed 4 □ Divorce  | arried                      | Armed F            | 2 🗆 No                        | Navy                       |              | Vas Decedent of Hi<br>f Yes, specify Cuba<br>I □ Yes 2ଢ़्र्र्No  | ispanic Ori<br>an, Mexicar<br>Specify: |             | cify Yes or N<br>Rican, etc.)       | 0-                     |                  | , White,                      |                         |              |
| in 72 hour<br>"natural  |       | Completed t       | 15. Decec<br>(Specify only hig  | ient's Educa<br>thest grade | ation<br>completed | )                             | 1 (0                       | Give         | lent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | durina mos                             | t of workir | ng                                  | 16b. k                 | (ind of Bus      | siness/In                     | dustry                  |              |
| d with<br>giene<br>er than  |       | E O               | Elementary/Secondary (0-12<br>12TH  | ,                           | College            | (1-4or 5+)                    |                            |              | LABORE   | R                                      |             |                                     | CO                     | NSTR             | UCT                           | ION                     |              |
| VICITY INTERPRETATION OF ITS 12 Should be filed within h and Menta! Hygiene. 7 Is marked other than traumatic event, the Me   |       | lo Be             | 17. Father's Name (First, Midd<br>JOSEPH JI   | lle, Last)<br>EFFER         | son,               | SR.                           |                            |              |  |  |             | (First, Middle<br>BETH              |                        |                  | e)                            |                         |              |
| 2 0 <del>1</del> 5 <del>1</del> 5   |       |                   | 19a. Informant's Name/Relation  |                             |                    | MER                           |                            |              | ng Address <i>(Street a</i>                                      |  |             |                                     |                        |                  |                               |                         | 213          |
| permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other  |       |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other                                  |                             | emoval fron        | n State                       |                            |              | sition (Name of natory or other place                            | <b>A</b> 1                             |             | ate<br>1,200                        | R                      |                  |                               | own, State              |              |
| permit. F Departm Importar any injur  | ouce. | -                 | 21. Signature of Funeral Serv   |                             | e                  | 7                             | GREEN                      | Č.           | OUNT CRI   | ss of Facili                           | ŘUGG        | S FUN                               | ERA                    |                  | ME                            |                         |              |
| WIST.   |       |                   | 23a. Part1. Enter the disease shock, or heart failure. I  | , or comun                  | ation that         | caused the                    | death. Do no               | t ent        | 412 E. I<br>er the mode of dyin                                  | PRES'<br>ig, such as                   | cardiac o   | STB<br>r respiratory                | arrest,                | O, MD            | 2                             | 1213<br>Approxim        | ate          |
| Physicia  | an    |                   | Immediate Cause (Final  | list only one               |                    |                               |                            |              |  |  |             |                                     |                        |                  |                               | Interval B<br>Onset and |              |
| /Medic  | al    |                   | disease or condition resulting in death)  | a.                          |                    | o (or as a co                 | onse uence of              |              | 9, 51  |  |             |                                     |                        |                  |                               | 4 004                   | \$           |
| Examin  |       |                   | Sequentially list conditions,   | b.                          | Sepa               |                               |                            |              |  |  |             |                                     |                        |                  | _                             | 1 day                   |              |
| ed /  |       | ji<br>J           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 4                           | Due to             | o (or as a co                 | onsequence of              | ):           |  |  |             |                                     |                        |                  |                               |                         |              |
| cate be executed ohysician and the burial-transit   |       | Examiner          | that initiated events<br>resulting in death) Last   | C.                          | Due to             | o (or as a co                 | onsequence of              | ):           |  |  |             |                                     |                        |                  |                               |                         |              |
| e be e<br>sician<br>buria   |       |                   |   | d                           |                    |                               |                            |              |  |  |             |                                     |                        |                  |                               |                         |              |
| tificat<br>ng phy<br>as the   |       | ledi              |   | 100                         |                    |                               |                            |              |  |  |             |                                     |                        |                  |                               |                         |              |
| The coulds, T.O. BOX 00/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   |       | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | 23                          | 1 ☐Live            | gnant at tim                  | Fetal death                |              | Ectopic pregnancy<br>Other (specify)                             | /                                      |             |                                     |                        | 23d. Date<br>Mor |                               | ery<br>Day              | Year         |
| Los, T.   |       | 2                 | Part II. Other significant cond   | litions cont                | tributing to       | death but n                   | ot resulting in t          | he ui        | nderlying cause give   | en in Part I                           | l.          |                                     |                        |                  |                               | the cause o             | _            |
| w requires to been signer should be   |       | Completed         |   |                             |                    |                               |                            |              |  |  |             | 24a. Wa                             | s an                   | 24b. V           | Vere auto                     | opsy finding            | ıs available |
| The law<br>e has l  |       | dmo               |   |                             |                    |                               |                            |              |  |  |             | aut<br>per                          | opsy<br>formed?        | -   p            | rior to co<br>l <u>ea</u> th? | mpletion of             | cause of     |
| cian: Tertificat  | -     | Be C              | 25. Was case referred to med  | ical                        |                    |                               |                            |              |  | 26. Place                              | of Death    | 1□ Yes<br>(Check only               |                        | 0   1            | □Yes                          | 2 No                    |              |
| rysici<br>nysici<br>nis cer<br>direc  |       | 8<br>2            | examiner?<br>1 ☐ Yes 2 ☑ No   | H                           | ospital:           | Inpatient                     | 2 ER/Outp                  | atier        | it 3 DOA Oth   | er:<br>4□Nu                            | ursing Hor  | ne 5 🗆 Res                          | sidence                | 6 □Othe          | er (Speci                     | fy)                     |              |
| nding Phy<br>ath.<br>r: After thi   |       |                   | Z LI Accident   | estigation                  | 28a. Date<br>(Mo   | e of Injury<br>onth, Day Yo   | ear) 28b. Tir              | ne oi<br>ury | Worl   | yat<br>k?<br>Yes 2□                    |             | 28d. Describe                       | e how inju             | ary occurre      | ed                            |                         |              |
| al or Atte<br>s after dec<br>il Directo   |       | Certification:    |   | uld not be<br>ermined       | 28e. Plac<br>buil  | ce of injury<br>ding, etc. (5 | - At home, fam<br>Specify) | n, str       | eet, factory, office   |  | 2           | 28f. Location<br>City or T          | (Street a<br>own, Stai |                  | er or Aur                     | al Route No             | ımber,       |
| To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page   |       | Medical (         |   |                             | er: On the         |                               | amination and/             |              | h occurred at the tir<br>vestigation, in my o                    |  |             |                                     |                        |                  |                               |                         | e(s)         |
| To th<br>Withir<br>To th  |       | M                 | 29b. Signature and title of cert  | ifier                       |                    |                               |                            |              | 29c. Licens  | e number                               |             |                                     | 29d. Da                | ate signed       | (Month                        | Day, Year,              | )            |
| ~   |       |                   | John Burger   | . Me                        | dicul              | Docto                         | -                          |              | Pes-   | - 000                                  |             |                                     | Apr.                   | 1 08             | , 2                           | 2008                    |              |
| y   |       |                   | 30. Name and address of pers  | on who cor                  | mpleted car        | use of death                  | n (Item 23a) (T            | уре,         | Print)   | 6                                      |             | 7                                   | .01                    |                  | -                             | 1297                    |              |
| · 8   | Stat  | e.                | 30. Name and address of persons.  31. Date filed (Month), Day, Ye APR 1                                     | ar)                         | 32.                | رمون المنظمة<br>gistrar's     | Signature                  | .5.          | orth Cuif  | e Str                                  | cet,        | Delhour                             | L TYla                 | ryland           | , 2                           | 1001                    |              |
| Reg   |       | ar                | APR 1   | 1 200                       | 08                 |                               | , K                        | nation of    | and I  |  |             |                                     |                        |                  |                               |                         |              |
|   |       |                   |   |                             | -                  |                               |                            | C.           |  |  |             |                                     |                        |                  |                               |                         |              |

Registrar DHMH 17 Rev 1/2001

| eorge Kyland I  |   | St.   | ate of Maryla                           | nd / Depa         |                               |   |  | al Hygiene                               | -og.o.c               | 20                         | 800                           | 185         |
|---|---|---|---|-------------------|-------------------------------|---|--|--|-----------------------|----------------------------|-------------------------------|-------------|
| Physicia  |   | Registrar<br>1. Decedent's Name (First, Middl                   | e.Last)                                 | Cei               | incate t                      | Dealli                                  |  | 2. Date of I                             | Reg. No.<br>Death     |                            | 3. Time of De                 | eath        |
| Aedical Exami   | 4.11  |   |   | nill              |                               |   |  | Month<br>April 5,                        | 2008                  | Year                       | 0753 hr                       | 1           |
| 27  |   | 4a. Facility Name (if not institution                           |   |                   |                               | 4b. City, Town,                         | , or Location of                             |  |                       | County of De               | eath                          |             |
|   |   | 1231 Neighbors Aven   | ue                                      |                   |                               | Rosedale                                | )  |  | Ba                    | altimore C                 | County                        |             |
| Funeral   |   | 5. Social Security Number                                       | 6. Sex                                  | 7. Age (In yrs. I | ast birthday)                 | If Under 1 \                            |  |  | Birth(MM/D            |                            | . Birthplace (State<br>oreign | or          |
| Director  |   | 220.50.7842   | 1 M 2 F                                 | 57                | Y                             | Months D                                | Days Hours                                   | Min. 0.5                                 | 27.19                 | 150                        | Country) MD                   |             |
|   | į   | Usual Residence of Decedent                                     |   |                   |                               |   |  | 100                                      | - / • - /             |                            |                               |             |
| * any   |   | 10a. State 10b. County  |   | 10c. City,        | , Town or Loc                 | ation                                   |  |  |                       |                            | 10d. Inside (                 |             |
| Aaryland<br>28a-f show<br>1 at once.  | ō   |   | timore                                  | Ro                | sedal                         |   |  |  |                       |                            | 1 Yes                         | 2 No        |
| Mary<br>28a-  | Director  | 10e. Street and Number  |   |                   |                               | 10f. Zip Cod                            |  |  |                       | en of What (               | Country?                      |             |
| ith the M<br>23a or 2<br>notified   |   |   | bors Ave                                |                   |                               | 2123                                    |  |  |                       | S.A.                       |                               |             |
| th wit  | eral  | 11. Marital Status  1 Never Married 2 M                         |   | edent Ever in U   |                               |   |  | n? (Specify Yes o<br>Puerto Rican, etc.) |                       | 14. Race - Al<br>White, et | merican Indian, B<br>c.       | ack,        |
| or it   | Fun   |   | 1 Yes                                   | 2 No              |                               |   | M  |  |                       | O                          | 716                           |             |
| s afte  | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give |   |   |                   |                               |   |  |  |                       | Specify: \ ind of Busine   | White                         |             |
| 2 hours natur   | ted   | Elementary/Secondary (0-12)                                     | College (1-                             |                   |                               | most of working                         |  |  | 100.10                | ina or basine              | 233/ Widdod y                 |             |
| 136<br>hin 7,<br>than<br>dical  | ed  | 12  | 0055 (                                  | , =, = ,          | Serv                          | ice St                                  | ation  | Attend                                   | ant P                 | etro                       | leum                          |             |
| sd with   | Completed   | 17. Father's Name (First, Middle,                               | Last)                                   |                   | 1                             |   |  | Name (First, Midd                        |                       |                            |                               |             |
| 21215-0036 ruld be filed within 7 Mental Hygiene. marked other than c event, the Medica   | Be (  | George Dewey  | v Knill                                 |                   |                               |   | Vir  | oinia N                                  | Jilme                 | 70                         |                               |             |
| 21<br>could d Mer<br>s mar  | ပ္  | George Dewer  19a. Informant's Name/Relations                   |   |                   |                               |   |  | oinia<br>Per or Rural Route              |                       |                            |                               |             |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, th. Medical Examiner must be notified at once                                |   | Sandra Knil   | L/Wife                                  |                   | 123                           | 1 Neig                                  | hbors  | Ave.,                                    | Rosed                 | ale,                       | MD 212                        | 37          |
| re,<br>slan<br>fres<br>frite<br>ertr  |   | 20a. Method of Disposition  1 Burial 2 Cremation                | 3 Removal fro                           |                   | Place of Disp<br>crematory or | osition (Name of<br>other place)        | cemetery,                                    |  |                       |                            |                               |             |
| Page<br>Page<br>nent c  |   | 4 Donation 5 Other S  |   | Ch                | esape                         | ake Cr                                  | em.  | 04.11.0                                  | 08 Ch                 | esape                      | eake'Cr                       | em          |
| Baltimore,<br>permit. Pages I ar<br>Department of Her<br>Important: If ite  | ı   | 1. Signature of Funeral Service                                 |   | noil              | 13 22                         | Name and Add                            | ress of Facility                             | CAFA/S                                   | tephe                 | n D.                       | Lohrma                        | nn          |
| E 57 E  |   | Lyda Sue  | MITHE.                                  |                   | 8                             | /1/ Gr                                  | een Pa                                       | istures                                  | Dr.                   | Balti                      | lmore,                        | MD          |
| Physician /Medical  |   | 23a. Part I. Enter the disease, or failure. List only one cause | on each line.                           |                   |                               |   | ing, such as ca                              | rdiac or respirator                      | arrest, sho           | ck, or heart               |                               | Onset and   |
| xaminer   | İ   | Immediate Cause (Final disease or condition resulting in death) |   |                   |                               | l burns                                 |  |  |                       |                            | De                            | ath         |
|   |   |   | Due to (or as a                         | consequence o     | of):                          |   |  |  |                       |                            |                               |             |
|   | 횰   | Sequentially list conditions,<br>if any, leading to immediate   | Due to (or as a                         | consequence o     | of):                          |   |  |  |                       |                            |                               |             |
|   | Examiner  | cause. Enter Underlying Cause (Disease or injury that initiated | c.                                      |                   | - 0                           |   |  |  |                       |                            |                               |             |
| 179.ª - #   |   | events resulting in death) Last                                 | Due to (or as a d.                      | consequence o     | or):                          |   |  |  |                       |                            |                               |             |
| be executed ician and irial - transi  | dical   | UNPENDED  | AMENDED                                 |                   |                               |   |  |  |                       |                            |                               |             |
|   | Med   | IF FEMALE:  | 7-7-5-7-8                               | outcome of preg   | inancy                        |   |  |  | 230                   | I. Date of del             | livery                        | _           |
| 387<br>rtifica<br>ling pl<br>as th  | any   | 23b. Was decedent pregnant in the past 12 months?               | ne 1 Live bi                            |                   | 17                            | Fetal death                             | 3 Ectopic                                    | pregnancy                                |                       | Month                      | Day                           | Year        |
| Box 68760, e death certificate be the attending physical for use as the bu  | Sici  |   |   | ant at time of de | eath 5                        | Other (Specify)                         |  |  | - 1                   |                            |                               |             |
| D. Be<br>t the de<br>by the   | Physician/Me  | Part II. Other significant condit                               | 9 OTIKIO                                |                   | resulting in the              | - underlying cau                        | se given in Par                              | t 1 23e. [                               | Did tobacco           | use contribut              | te to the cause of            | death?      |
| P.O. E es that the digned by the  | ρ   | art II. Other significant condi-                                | ions contributing to                    | deall but not     | resulting in the              | e unuerrying cau                        | ise given in r ai                            | · · ·                                    | , ,                   |                            | Probably 4                    |             |
| cords, P.O. law requires that has been signed to should be deta   | Completed   |   |   |                   |                               |   |  | <br>  24a. \                             | Vas an                | 1 24b. Wei                 | re autopsy finding            | s available |
| Orc<br>law re<br>has be<br>2 sho  | 휥   | <u> </u>  |   |                   |                               |   |  | 8  | autopsy<br>performed? |                            | r to completion of            |             |
| tal Recol   | 힝   |   |   |                   |                               |   | <u> ·                                   </u> | 1 _ \                                    | ′es 2 ✔ N             |                            | Yes 2                         | No          |
| of Vital Records, ng Physician: The law require nfer this certificate has been si neral director, page 2 should t   | Be  | 25. Was case referred to medica examiner?                       | Hospital:                               |                   | ]                             |   | Other  | Check only one)                          |                       |                            | 211 - 0                       |             |
| f Vir   | မ   | 1 ✓ Yes 2 No<br>27. Manner of Death                             | 28a. Date                               | npatient 2        | ER/Outpatie                   |   | Injury at Work?                              | Nursing Home 5                           | ribe how inju         |                            | Other: Scene                  |             |
| n of iding Ph   | Certification:  | 1 Natural 5 Pen   | EO(MRITE:                               | Day,Year)         | FOUND:                        | 1                                       | Yes 2  | House                                    |                       | , 000000                   |                               |             |
| Division pital or Attendir ours after death eral Director: A  | cat   | 2 🗸 Accident Inve   | stigation Apr 5, 20                     |                   | 0741 hrs                      | reet, factory, offi                     |  |  | on (Street a          | nd Number o                | or Rural Route Nu             | mber, City  |
| Divi  | Ę   | dete  | d not be                                | Rowhouse          |                               | , |  | or To                                    | vn, State)            | enue, Ros                  |                               |             |
| Hospii<br>4 hous<br>7uner<br>3ly fill   |   |   | hysician: To the bes                    |                   |                               | curred at the time                      | e, date and plac                             |  | <del></del>           |                            |                               |             |
| Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the broadless. | Medical   | one) 2 Medical Exa  | miner: On the basis of<br>and manner st | of examination a  | and/or investi                | gation, in my opi                       | nion, death occ                              | curred at the time,                      | date and pla          | ce, and due                | to the cause(s)               |             |
| ¥ ½ ½ 8   | Me  | 29b Signature and title of certific                             |   | area.             |                               | 29c. Lic                                | cense number                                 |  | 29d.                  | Date signed                | (Month, Day, Yea              | r)          |
|   |   | layine 18   | rellall                                 |                   |                               | 0                                       | .C.M.E.                                      |  | Apri                  | 16, 2008                   |                               |             |
| 12  |   | 30. Name and address of persor                                  | who completed caus                      | e of death (Iter  | m 23a)                        |   |  |  |                       |                            |                               |             |
| 100   |   | Margarita Korell MD.  | Assistant Med                           |                   |                               | Penn Street                             | , Baltimore,                                 | , MD 21201                               |                       |                            |                               |             |
| S   | tate  | 31. Date filed (Month, Day, Year)                               |   | gistrar's Signat  | ture                          | sele)                                   |  |  |                       |                            |                               |             |

08-02491 Javon G. King

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|----|---|---|---|---|---------|---|----------------|
| 2  |   | U | Ö | i | and the | 8 | 0              |

|   |   |  | 1- For State<br>Registrar   |   | Cert                            | ificate of                         | Death                          |            |                    |            |             | Reg. No            |                    |                              |   |
|---|---|--|---|---|---------------------------------|------------------------------------|--------------------------------|------------|--------------------|------------|-------------|--------------------|--------------------|------------------------------|---|
|   | Physicia  | an/  | 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day  Year  01081 |   |                                 |                                    |                                |            |                    |            |             |                    |                    | 3. Time of Death<br>0108 hrs |   |
|   | ' Exami   | ner  | Javon Garrett   |   |                                 | 14                                 | b. City, Tow                   | n orlo     | cation of          |            | March 3     | 30, 200            | c. County of       | f Death                      | 01001110  |
|   |   |  | 4a. Facility Name (if not institution Sinai Hospital                              | on, give street and n                     | umber)                          | "                                  | Baltimor                       |            |                    | Dodan      |             |                    | N/F                |                              |   |
|   | Funeral   |  | Social Security Number  | 6. Sex                                    | 7. Age (In yrs. las             | st birthday)                       | If Under 1                     | Year       | If Under           | 24Hrs.     | 8. Date of  | Birth(MN           | VDD/YYYY)          | 9. Birth                     | pplace (State or                                    |
|   | Director  |  | 217-23-5353   | 1X M 2 F                                  | 19                              | Yrs.                               | Months                         | Days       | Hours              | Min.       | Feb.        | 28,                | 1989               | Cou                          | Maryland  |
|   |   |  | Usual Residence of Decedent   | <u> </u>                                  | <u> </u>                        |                                    |                                | i          |                    |            |             |                    |                    |                              |   |
|   | any   |  | 10a. State 10b. County  |   | 1                               | Town or Location                   |                                |            |                    |            |             |                    |                    |                              | 10d. Inside City Limits                             |
|   | show  | 'n   | Maryland N/   | A   | Ba]                             | ltimore                            |                                |            |                    |            |             |                    |                    |                              | 1 X Yes 2 No  |
|   | Maryla<br>28a-f<br>1 at o   | Director   | 10e. Street and Number  |   |                                 |                                    | 10f. Zip Co<br>212             |            |                    |            |             |                    | tizen of Wh<br>JSA | at Coun                      | try?  |
|   | death with the Maryland or items 23a or 28a-f show must be notified at once.  |  | 5425 Nelson Ave   |   |                                 |                                    |                                |            |                    | 0.10       | 15. 14      |                    |                    | A-m-n-i-                     | can Indian, Black,                                  |
|   | th wit  | Funeral  | 11. Marital Status  1 XNever Married 2 N  |   | ecedent Ever in U.S<br>Forces?  |                                    | s Decedent of<br>es, specify C |            |                    |            |             |                    | White              | , etc.                       |   |
|   | or it   | Fur  |   | 1 Yes                                     | 2 X No                          | 1                                  | Yes 2 X                        | No         | specify:           |            |             |                    | Specify:           | lack                         |   |
|   | urs aft   | 15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT us |   |   |                                 |                                    |                                |            |                    |            | rk done     |                    | . Kind of Bu       |                              |   |
|   | 72 hou  | etec   | Elementary/Secondary (0-12  | ) College                                 | (1-4 or 5+)                     |                                    |                                | ig life. E | OO NOT L           | ise retire | ed)         | Ho                 | me Imp             | prov                         | ement   |
| 036   | ted within 72 hours after<br>Hygiene.<br>other than "natural",<br>the Medical Examiner  | Completed  | 12Years   |   |                                 | Laborer                            |                                |            |                    |            |             |                    |                    |                              |   |
| 5-0   | Hygie<br>Hothe  |  | 17. Father's Name (First, Middle  | e, Last)                                  |                                 |                                    |                                |            |                    |            | M. Mo       |                    | n Surname          | )                            |   |
| 121   | ld be fil<br>Aental F<br>narked<br>event,   | ) Be   | James E. King  19a. Informant's Name/Relation                                     | ehin (Tyne Print )                        |                                 | 19b. Mailing                       | Address                        |            | -                  |            |             |                    |                    | n, State                     | , Zip Code)   |
| 0   | and N<br>and N<br>27 is n<br>matic  | 10   | Cynthia Monroe  |   |                                 | 5425 N                             | Telson                         | Ave        | enue               | Ba         | ltimo       | re,                | Maryla             | and                          | 21215   |
| <u>ک</u>  | and 2 sh<br>Health an<br>item 27 i  |  | 20a. Method of Disposition  |   |                                 | Place of Dispos<br>rematory or otl |                                | of cem     | etery,             |            | Date        | 200                | c. Location -      | - City or                    | Town, State   |
| nor   | permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene Department of Health and Mental Hygene I have "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | İ  | 1 Burial 2 Crematic   |   | from State Kine                 | g Memor                            | ial P                          | ark        |                    | 4/5        | /08         | Wo                 | odlaw              | n, M                         | Maryland  |
| altin.  | permit. P<br>Departme<br>Importar<br>injury or  |  | 4 Donation 5 Other S 21. Signature of Funeral Service                             |   |                                 | 22. N                              | Name and Ad                    | ddress     | of Facility        | Cha        | tman-       | Harr               | is Fw              | nera                         | l Home  |
| ä   | Dep<br>Imje   |  | Deray J   | Harris                                    |                                 | 524                                | 10 Rei                         | ste        | rstov              | vn R       | oad E       | alti               | more,              | Mary                         | land 21215  |
|   | ysician   |  | 23a. Part I. Enter the disease, of failure. List only one caus                    | or complications that<br>se on each line. | t caused the death.             | . Do not enter t                   | he mode of                     | dying, s   | uch as ca          | ardiac or  | respirator  | y arrest, s        | shock, or he       | aπ                           | Approximate Interval Between Onset and Death        |
|   | vledical<br>kaminer   |  | Immediate Cause (Final diseas   | se a Multiple C                           | Sunshot Woun                    |                                    |                                |            |                    |            |             |                    |                    |                              | Deatil  |
|   |   |  | or condition resulting in death)  | Due to (or as                             | s a consequence of              | 1):                                |                                |            |                    |            |             |                    |                    |                              |   |
|   |   | Jer  | Sequentially list conditions, if any, leading to immediate                        | Due to (or as                             | s a consequence of              | f):                                |                                |            |                    |            |             |                    |                    |                              |   |
|   |   | Examine  | cause. Enter Underlying Caus<br>(Disease or injury that initiated                 | C.  | s a consequence of              | f):                                |                                |            |                    |            |             |                    |                    |                              |   |
| M   | d<br>ansit  | Ä  | events resulting in death) Last   | d.  | o d odnovijavnika a             | -7-                                |                                |            |                    |            |             |                    |                    |                              |   |
| •   | ficate be executed g<br>g physician and<br>s the burial - transit   | /Medical   | UNPENDED  | AMENDE                                    | D                               |                                    | -                              |            |                    |            |             |                    |                    |                              |   |
| , <sup>60</sup>   | ate be  | Med  | IF FEMALE:  |   | s, outcome of preg              | nancy                              |                                |            |                    |            |             |                    | 23d. Date o        |                              |   |
| 687   | ding<br>se as t   | ian/   | 23b. Was decedent pregnant in past 12 months?                                     |   | e birth<br>egnant at time of de |                                    | etal death<br>ther (Specif     |            | Ectopic            | pregna     | ncy         |                    | Month              |                              | Day Year  |
| 30X   | leath<br>e atte   | Physicia   | 1 Yes 2 No 9 U  | Introduce T                               | known                           | 3 0                                | ther (Specia                   | y/         |                    |            |             | -                  |                    |                              |   |
| 0.  | Jing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as   | 된  | _   | ditions contributing                      | g to death but not re           | esulting in the                    | underlying o                   | ause gi    | iven in Pa         | art I.     |             |                    |                    |                              | the cause of death?                                 |
| σ.  | res th<br>signed<br>be de   | d b  |   |   |                                 |                                    |                                |            |                    |            |             |                    |                    |                              | bably 4 Unknown                                     |
| rds   | requi   | ompleted   |   |   |                                 |                                    |                                |            |                    |            |             | Was an autopsy     |                    | prior to                     | utopsy findings available<br>completion of cause of |
| eco   | he lav<br>ite has   | E E  |   |   |                                 |                                    |                                |            |                    |            |             | performe<br>Yes 2  |                    | death?<br>1 🕜 Y              | 'es 2 No  |
| 꼾   | an: T<br>ertifica<br>stor, p  | Ü  | 25. Was case referred to medi-  |   |                                 |                                    | 26                             |            | of Death           | (Check     | only one)   |                    |                    |                              |   |
| Vit.  | hysici<br>this co<br>I direc  | B  | 1 ✓ Yes 2 No  | Hospital: 1                               | Inpatient 2                     |                                    |                                |            | Other <sub>4</sub> |            | g Home      |                    | sidence 6          | Othe                         | er:   |
| 28d. Dete of Injury 28b. Time of Injury 28c. Injury at Work? 28d. De Subject 1 Natural 5 Peopling Mar 30, 2008 2008 2008 2008 2008 2008 2008 20 |   |  |   |   |                                 |                                    |                                |            |                    | Subject    |             | injury occu<br>not | rrea               |                              |   |
| Value 5 Pending Investigation Investigation 2 2 Accident Pending Investigation 2 28e. Place of Injury - At home, farm, street, factory, offi    |   |  |   |   |                                 |                                    |                                |            |                    | 1          | 28f Loca    | tion (Stre         | et and Num         | her or F                     | tural Route Number, City                            |
| j×į   | ≥ 5 € 5 € 5 E Suicide Could not be  |  |   |   |                                 |                                    |                                |            | ulluling, e        |            |             |                    |                    |                              | Itimore, MD   |
|   | lospits<br>I hours<br>unera<br>ly fille   |  |   | Physician: To the                         | hest of my knowled              | ige, death occu                    | urred at the t                 | time, da   | ate and pla        | ace, and   | due to the  | e cause(s          | ) and mann         | er as sta                    | ated.   |
|   | To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical  | (Check only one) 2 Medical E  | xaminer: On the bas                       | sis of examination a            | and/or investig                    | ation, in my                   | opinion    | , death o          | ccurred a  | at the time | date and           | place, and         | due to                       | the cause(s)  |
|   | To Italian  | Me   | 29b. Signature and title of cert  | and manne<br>ifier                        | o stateu                        |                                    | 29c.                           | Licens     | e number           |            |             | 2                  | 9d. Date sig       | ned (M                       | onth, Day, Year)                                    |
|   |   |  | Canul & Sivis   | theul, m                                  | $\triangle$                     |                                    |                                | O.C.I      | M.E.               |            |             | N                  | March 30           | , 2008                       |   |
|   | 4   |  | 30. Name and edgress of pers  |   |                                 |                                    | 44.5                           | <u> </u>   | 4 D - 111          |            | AD 040      | 24                 |                    |                              |   |
|   |   |  | Pamela E. Southall,   |   | nt Medical Exa                  |                                    | 11 Penn                        | Stree      | ı, Baitin          | nore, I    | VID 2720    |                    |                    |                              |   |
|   | S<br>Regis  | State  | APR I I   | <sup>2</sup> 2008                         | Registrar's Sign                | ure (1)34                          | (L)                            |            |                    |            |             |                    | JulviE             |                              |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 12: 05 PM 08 2008 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Peath Examiner Baltimore Washington Medical Center Alenizumie 8. Date of Birth (Month, Day, Year) Under 1 Year If Under 24 Hrs. onths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 57 A 30-1024 Usual Residence of Decedent 1 □ M 2 📉 Director MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 41 Chester Circle 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Laughton Elizabeth Gertrude Herberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any injury or other trau Mr. Earl Kinsey / husband 41 Chester Circle; Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 4-14-2008 Elkridge, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 1 2nd Ave SW; Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DePsi > disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liberton or injury) Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760 physician Physician/Medical as aftending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknowr signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11.19 00060721 08 2008

10

State Registrar 31. Date filed (Month, Day, Year)

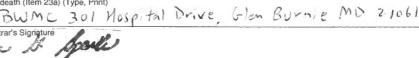
APR 1 1 2008

Registrar's Signature

Kolvardo Falcon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 Kofack /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland medical cente Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Hours 1⊠M 2□F Months 08-25-1936 II. Director 333-28-8273 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at a or 28a-f she t be notified a 1 □Yes 2KINo Director Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a 21060 U.S.A. 310 Marie Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Computers Computer Specialist permit. Pages 1 and 2 should be filed very Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Zuba Frank Kopack ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Marie Ave.; Glen Burnie, MD 21060 Ms. Diane Diluca/companion Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park | 08-12-2008 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 1 2nd Ave SW; Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhage Physician Intra cerebro /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transi and Due to (or as a consequence of): Box 68760. nding physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 Yes 2 No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 26. Place of Death (Check only one) Be Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Creene Baltimore (MD 2120) Ada Poli 20 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 1 1 2008

ORIGINAL

|                            |  |                                  | For State Registrar  | State of Marylai  |                                     | rtment of H<br>tificate of L                                     |  | ınıaı myglel<br>.Reg.                     |   |  |
|----------------------------|--|----------------------------------|--|---|-------------------------------------|--|--|---|---|--|
| -                          | Dhyminia   |                                  | 1. Decedent's Name (First, Middle, Las   | i e   |                                     |  |  | 2. Date of Death                          | Day 20 Year                                     | 3. Time of Death                                   |
|                            | Physicia<br>/Medic   | al                               | Jadvyga J.  4a. Facility Name (If not institution, give  | Kalnietis   |                                     | Ab City Town or  | Location of Death                          | *11                                       | 2008<br>4c. County of Death                     | 17:15A,  |
|                            | Examin   | er                               | Baltimore Washing  |   | enter                               | Glen E   |  |   | Anne Arı  |  |
|                            | Funeral<br>Director  |                                  | 213 30 0337  |   | s. <i>last birthday)</i><br>97 Yrs. | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs. Hours Min.                | B. Date of Birth (Month, Day, Ye 10-27-19 | 9. Birth<br>Cou                                 | place (State or Foreign<br>ntry)<br>Lithuania      |
|                            | /land<br>ow<br>at  |                                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. C  | City, Town or Loc                   |  |  |   |   | 10d. Inside City Limits                            |
|                            | e Mary   | ctor                             | MD Anne Ar   | undel   | G1                                  | en Burnie  |  |   |   | 1 □ Yes 2 No                                       |
| 7                          | th with the 23a or 23 ust be no  | ral Dire                         | 10e. Street and Number<br>313 Hospital Dri   | ve  |                                     |  | .061                                       |   | U.S.A   | •  |
| 15-0036                    | be filed within 72 hours after death with the Maryland tital Hygiene. In whatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Be Completed by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ፟ Widowed 4 □ Divorced  | 12. Was Decedent Ever in I<br>Armed Forces?<br>1  | 1                                   | ☐ Yes 21 No  | spanic Origin? (Specin, Mexican, Puerto Ri |   | 14. Race - Ameri<br>Black, White<br>Specify: Wh | , etc.<br>Lte                                      |
| A 5-                       | n 72 h<br>" <b>natu</b><br>edl al  | letec                            | 15. Decedent's Ed<br>(Specify only highest gra   |   | 16a. Deced<br>(Give life, D         | ent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | ation<br>furing most of working<br>)       | 7   | . Kind of Business/h                            | ndustry  |
| X 512                      |  | omo                              | Elementary/Secondary (0-12)  | College (1-4or 5+)  | 1                                   | emaker   |  |   | Own Home  | 3  |
| and *                      | ould be filed<br>Menta! Hygi<br>arked other<br>atic event, tl  | To Be (                          | 17. Father's Name ( <i>First, Middle, Last</i> )  Andrius Aukstuol   |   |                                     |  | 18. Mother's Name ( Elizabe                | First, Middle, Maid<br>th Auksti          |   |  |
| √ Y CAA<br>Maryland        | nd 2 should<br>aith and Men<br>27 Is marke<br>ir traumatic   |                                  | 19a. Informant's Name/Relationship (** Mr. Al Kalnietis  | **  |                                     |  | and Number or Rural<br>Lre Drive           |   |   | ip Code)<br>21108                                  |
| JAD altimore,              | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If Item 27 is marke<br>any Injury or other traumatic<br>once.                       |                                  | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi  | Removal from State  | esapeak                             |  | lon 04/10                                  | -2008 St                                  | Location - City or T<br>tevensvil               | Le, MD   |
| Balti                      | permit. Departr Imports any Inju   |                                  | 21. Signature of Funeral Service Licer   | LICA WILL   | 1 11                                |  |  |   |   | remation Srv<br>)61                                |
| •                          | Physician<br>/Medical<br>Examiner  |                                  | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Seguentially list conditions. | a. Due to (or as a conse  | equence of):                        | er the mode of dyin  | g, such as cardiac or                      | respiratory arrest,                       |   | Approximate<br>Interval Between<br>Onset and Death |
| 68760,                     | tificate be executed ig physician and as the burial-transit  | edical Examiner                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last             | cDue to (or as a conse  |                                     |  |  |   |   |  |
| .О. Вох                    | The law requires that the death certific tte has been signed by the attending page 2 should be detached for use as it  | Physician/Mec                    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome pf preg<br>1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | etal death 3□                       | Ectopic pregnancy  |  |   | 23d. Date of deli<br>Month                      | very<br>Day Year                                   |
| rds, P.                    | quires that<br>n signed b  | þ                                | Part II. Other significant conditions of   | ontributing to death but not re   | esulting in the ur                  | nderlying cause give   | en in Part I.                              | 23e. Did tobac<br>1 ☐ Yes                 | co use contribute to                            | the cause of death?<br>obably 4  Unknown           |
| Division or Vital Records, |  | Completed                        |  |   |                                     |  |  | 24a. Was an autopsy performed             | <b>⅓</b> ?   death?                             | topsy findings available ompletion of cause of     |
| Vita                       | lclan<br>certifi<br>ector  | Be                               | 25. Was case referred to medical examiner? 1 ☐ Yes 2 M No  | Hospital:   |                                     | t 3D DOA Othe  | 26. Place of Death                         |   |   |  |
| on or                      | Phy<br>this  | ion: To                          | 27. Manner of Death 1 Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of                        | 28c. Injur<br>Worl   | 4 Inuising Hom                             | e 5 L Residenc                            | e 6 □Other (Specinjury occurred                 | ify)   |
| Divisio                    | l or Attending<br>after death.<br>Director: After<br>in by the funer   | Certification:                   | 2 (1) Accident investigation 3   Suicide 6   Could not be determined   |   | home, farm, stro<br>cify)           |  |  | Bf. Location (Stree<br>City or Town, S    | et and Number or Ru<br>State)                   | ral Route Number,                                  |
| _                          | To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the   | Medical Co                       |  | ysician: To the best of my kininer: On the basis of examinand manner stated.                    |                                     |  |  |   |   |  |
|                            | To the within 2 To the complet   | Me                               | 29b. Signature and title of certifier  | hm  |                                     | 29c. Licens  | e number - 3 9 7 7                         | 29d.                                      | Date signed (Month                              | Dock   |
|                            | 4  |                                  | 30. Name and address of person who   | completed cause of death (Ite   | em 23a) (Type,                      | Print)   | 0  | 1.0                                       | Sin!  | ~~~  |
|                            | Sta  | te                               | 31. Date filed (Month Pay, Year)   | 20 32 degistar sig  | inature (                           | ver you  | Brime                                      | MD.                                       | 2106  | 4  |
|                            | Registr  |                                  | APR 1 1/20   | 100 Beech.  | 15 60                               | sull's   |  |   |   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

|  |   |                        | For<br>State<br>Registrar  | State of Mary  | -                               | rtment of<br>tificate of                                |  |  | giene<br>Reg. No               | 00 11055  |
|--|---|------------------------|--|--|---------------------------------|---|--|--|--------------------------------|---|
|  | Dhysisis  |                        | 1. Decedent's Name (First, Middle, Las   | •  |                                 | 77 - a C:   |  | 2. Date of Dea<br>Month                                    | Day                            | Year 3. Time of Death   |
|  | Physicia<br>/Medic  |                        | Victor   | R.   | 1                               | Kee St  | or Location of Dea   | 04   | 02 2                           | 2008 11:20p M   |
|  | Examin  | er                     | 4a. Facility Name (If not institution, give Ruxton Nursing   |  |                                 | Pi  | kesvill  | 2  | Bal                            | of Death<br>Ltimore   |
| B  | Funeral<br>Director   |                        | 5. Social Security Number 6. S 250-34-7706   | ex 7. Age (In  | yrs. last birthday) 3 Yrs.      | If Under 1 Year<br>Months Days                          |  |  | y, Year)                       | 9. Birthplace (State or Foreign Country)                        |
| <u> </u>   | 2   |                        | Usual Residence of Decedent  10a, State 10b, County  | 100  | c. City, Town or Lo             | cation  |  |  |                                | 10d. Inside City Limits   |
| Varyla   | f shovied at  | ō                      | MD NA  |  | *                               | imore   |  |  |                                | 1 X Yes 2 No  |
| the the  | r 28a-  | Director               | 10e. Street and Number   |  |                                 | 10f. Zip Code   |  |  | 10g. Citizen of V              | ·   |
| #<br>Wi  | 23a o<br>ust be   | ralD                   | 2020 Featherbe   |  |                                 |   | 1207   |  | U.S.                           |   |
| 21215-0036<br>ad within 72 hours after death with the Maryland | perimit. Fages I and a Should be men whilm rathrongs aren death with the way gail popularity of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral             | 11. Marital Status  1 ☐ Never Married      A☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give<br>Year or Dates: |                                 | Vas Decedent of<br>f Yes, specify Cu<br>I □ Yes 2√2 No  | Hispanic Origin? (<br>lban, Mexican, Pue<br>o <i>Sp</i> ec <i>ify:</i> | Specify Yes or No<br>rto Rican, etc.)                      | Blac<br>Specify                |   |
| 15-0   | "natur  | etec                   | 15. Decedent's Ec<br>(Specify only highest gra   | lucation<br>ade completed)   | 16a. Deced                      | lent's Usual Occ<br>kind of work don<br>OO NOT use reti | upation<br>e during most of wo<br>red)                                 | orking   | 16b. Kind of Bu                | usiness/Industry  |
| 121  | iene.<br>than   | Completed              | Elementary/Secondary (0-12) 10th grade   | College (1-4or 5+) <b>na</b>   | inc. I                          | Owner   | 55)  |  | TV Rep                         | air Shop  |
| br and 2   | other<br>vent, 1  | Be C                   | 17. Father's Name (First, Middle, Last)  | )  |                                 |   |  | ame (First, Middle,  |                                | ne)   |
| ylar<br>Suld b   | Menta<br>Menta<br>arked   | To E                   | George Kee   |  |                                 |   | Florenc  |  |                                | Otata 75 Orda)  |
| Mar  | Ith and<br>Ith and<br>27 Is m   |                        | 19a. Informant's Name/Relationship ( Bessie Mae Kee  |  | 19b. Mailir<br>2020             | Feath   | et and Number or F<br>erbed L  | ane, Ba  | ltimor                         | e, Md 21207   |
| Baltimore, Maryland  | rages I at<br>nent of Hea<br>int; If item ;<br>iry or other   |                        | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specific  | Removal from State   |                                 | sition (Name of<br>natory or other p<br>Mount           |  | Date<br>14/08  |                                | city or Town, State imore, Md                                   |
| Balti  | Departm<br>Departm<br>Importa<br>any inju   |                        | 21. Signature of Funeral Service Licer   | ark /  | I N                             | Name and Add  | ress of Facility<br>/H West<br>bash Av                                 | e. Balt  | imore,                         | Md 21215  |
| e.   |   |                        | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that caused the one cause on each line.   | death. Do not ent               | er the mode of d  | ying, such as cardi  | ac or respiratory a  | rrest,                         | Approximate<br>Interval Between<br>Onset and Death              |
|  | hysician  |                        | Immediate Cause (Final disease or condition resulting in death)  | a MULTI-   | INFAR                           | -T D  | EMENT  | 7A   |                                | yas   |
| E  | /Medical<br>xaminer   |                        | resulting in death)  | a. MULTI-<br>Due to (or as a co  | onsequence of):                 | card  | Biolesci   | la d   | isecse                         | yeas  |
| £ .  |   | Jer                    | Sequentially list conditions, if any, leading to immediate   | b. Due to (or as a co  |                                 | - Q   | 0.0000   | ,  |                                | 7 -   |
| 9  | nd<br>ransit  | amir                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  |                                 |   |  |  |                                |   |
| 11:20 PM<br>68760, C   | be exe  | edical Examiner        | resulting in death) Last   | Due to (or as a co   | onsequence of):                 |   |  |  |                                |   |
| 80 2   | physi<br>ts the b   |                        | •  | d  |                                 |   |  |  |                                |   |
| (08<br>Box   | e attending   | Physician/M            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim<br>9 ☐ Unknown      | Fetal death 3                   | ]Ectopic pregna<br>]Other <i>(specify)</i>              |  |  |                                | te of delivery<br>onth Day Year                                 |
| Records, P.O   | w requires triat the deben signed by the should be detached   | þ                      | Part II. Other significant conditions  | contributing to death but n  | ot resulting in the u           | nderlying cause   | given in Part I.   |  | tobacco use cont<br>Yes 2∐ No  | tribute to the cause of death?                                  |
| or Vital Record  | 2 33 8  | Completed              |  |  |                                 |   |  | 24a. Was   | psy                            | Were autopsy findings available prior to completion of cause of |
|  |   | Con                    |  |  |                                 |   |  | perfo<br>1□ Yes  | ormed?<br>No                   | death?<br>1 ☐ Yes 2 ☐ No  |
| Zi K   | ysician; in<br>is certificate<br>director, pag  | ) Be                   | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No   | Hospital:  | 2 ☐ ER/Outpatie                 | nt 3□ DOA   |  | eath <i>(Check only only only only only only only only</i> |                                | per (Specify)   |
| Vision or Vita   | aing rnys<br>h.<br>After this<br>funeral di   | n: To                  | 27 Manner of Death   | 28a. Date of Injury<br>(Month, Day Ye  | 28b. Time o                     |   | njury at<br>Vork?  |  | how injury occur               |   |
|  | engin<br>aath.<br>or: Aff<br>the fur  | atio                   | Natural 5 Pending  2 Accident investigatio  3 Suicide 6 Could not b  | n  |                                 | M 1   | ☐ Yes 2 ☐ No   |  |                                |   |
|  | or And<br>after de<br>Direct<br>in by t   | ıtific                 | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined   |  | - At home, farm, st<br>Specify) | reet, factory, offic                                    | ce   | 28f. Location (<br>City or To                              | (Street and Numb<br>wn, State) | ber or Rural Route Number,                                      |
| 3  | lo the Hospital of Attend within 24 hours after death.  To the Funeral Director: \( \) completely filled in by the f  | Medical Certification: | 29a. Certifier<br>(Check only<br>one)  | hysician: To the best of miner: On the basis of ex<br>and manner stated                    | amination and/or in             | h occurred at the                                       | e time, date and pla<br>ny opinion, death o                            | ce, and due to the<br>curred at the time                   | e cause(s) and m               | anner as stated.<br>and due to the cause(s)                     |
|  | vithin 2 To the complet   | Me                     | 29b. Signature and title of certifier  | 22   | ^                               | 29c. Lice   | ense number  |  | 29d. Date signe                | ed (Month, Day, Year)   |
|  | -   |                        | Dendal.  | Halll  | lio                             | 7) 9  | 5643   |  | 04/0                           | 3/2008  |
|  | 3   |                        | 30. Name and address of person who   | completed cause of death   | h (Item 23a) (Type,             | Print)  | + Suete  | 209/Ba   | etimoc                         | 3/2008<br>MD 21204  |
|  | Sta<br>Registi  |                        | 31. Date filed (Month, Pay, Year)  | 2008 32. Jegistrar's   | Signature                       | houle   |  | 1  |                                |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carrie Kenny 2008 /lonth Physician 9:50 PM /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner uture wre-U4D (OUY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 SF Months 239-32-385 Carolina Director North Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No **Funeral Director** Timos 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Brals, de 6000 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ō Specify: Be Completed by 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nursing urse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOWN tai Kichard nenc ပ္ 19a\_Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is: any Injury or other traus renda - niece md, 21229 eside to. 606 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State Na 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service License 23a. Par 1 Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on such line.

Immedia of the cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of the cause). Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Herose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the burial IF FEMALE yes, outcome of pregnancy
Live birth 2 🗆 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2/2/10 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Mapper of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 'Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:15 P<sup>M</sup> 2008 MATTHEW CONNER LIEBL MAR 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□F **Director** 577-47-0696 28, 2008 Feb. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Director VA Prince William Manassas 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or ms 23a 8378 Tillett Loop 20110 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Married 2 Married White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) the N/A N/A0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth æ ည Liebl Teresa Bruce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 8378 Tillett Loop, Manassas, Randy Liebl/Father VA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hokes Bluff
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-28-08 | Hokes Bluff, AL 22. Name and Address of Facility Glencoe-Hokes Bluff FC 3-28-08 21. Signalun Funeral Service Licensee 1901 Piedmont Cutoff, Glencoe, AL 35905 23a. Part. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

In editate Cause (Final disease or condition

NECROTIZING ENTEROCOLITIS **Physician** NECROTIZING ENTEROCOLITIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EXTREME PREMATURITY Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 XInpatient 2 ER/Outpatient 3□ DOA မ 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Attending (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or within 24 hours after To the Funeral Di completely filled in 29a. Certifier I XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar MAUREEN L. TATE

auren I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

Baltimore.

Records, P.O. Box 68760,

Division or Vital

MD 048338-L (PA)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

03-25-2008

| ician  | State of Maryland / Pep<br>Per Phy G878 4/11/<br>1. December: Name (First, Middle, Last)  Marshall Landis  |   |  |   |   | 2. Date of Death April 5 <sup>Day</sup> 200  |  | 8 <sup>Year</sup>  | 3. Time of Death<br>12:47 PM <sub>M</sub>   |
|--|--|---|--|---|---|--|--|--|---|
| niner 4a Faci  | ility Name (If not institution, give<br>B Hopkins Road   | 4b. City, Town, or  | Location of Death<br>Baltimore   |   |   | ty of Death  |  |  |   |
| al 5. Socia 194  | 1 Security Number 6. Set 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 9x 7. Age (<br>M 2□F  | (In yrs. last birthday)<br>60 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birt  | 71947  | 9. Birthpl<br>PA Coun  | ece (State or Foreign<br>try)   |
|  | Residence of Decedent ate 10b. County Baltimo  |   | 10c. City, Town or Lo  |   |   |  |  | 10   | 0d. Inside City Limits  |
| 10e. Str<br>10e. Str   | 10e. Street and Number 108 Hopkins Road  |   |  |   |   |  | 10g. Citizen of What Country? United States  |  |   |
| by Fur   | rital Status  Never Married 2⊠ Married  Widowed 4 □ Divorced   | 12. Was Decedent Ev<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:  | 1  | Was Decedent of Hi<br>f Yes, specify Cuba<br>1 ☐ Yes 2⊠No                       | ispanic Origin? (Spe<br>in, Mexican, Puerto<br>Specify:   | ecify Yes or No-<br>Rican, etc.)   | Blac   | e - Americ<br>k, White, o  | etc.  |
| Completed  | 15. Decedent's Ed<br>(Specify only highest gradentary/Secondary (0-12)   | ucation<br>de completed)<br>Coltege (1-4or 5+)  | (Give  | DO NOT use retired  | during most of worki  | ing  | 16b. Kind of Bu<br>Jemar   | isiness/Inc  | lustry  |
| 17. Fath   | ner's Name (First, Middle, Last)   | is  |  | 18. Mother's Name (First, Middle, I<br>Anita Johnson                            |   |  | Maiden Surname)  |  |   |
| 19a. In<br>Ka  | formant's Name/Relationship <i>(7</i><br>thleen Landis/Wi  | rype, Print)<br><b>fe</b>   |  |   | and Number or Rura<br>Road Balti  |  |  |  | Code)   |
| 20a. Me<br>1 [<br>' 4 [  | athod of Disposition  Burial 2 Cremation 3   Donation 5 Other (Specify   |   | 20b. Place of Dispo<br>carnetery, cren<br>Chesapea   | natory or other place   | cory Inc.   | Apr 10<br>2008   | 20c. Location - Beltsvil   |  |   |
| 21. Sig  | nature of Funeral Service Licens   | see Moly  | . \  |   | Pastures  |  |  | , Mar  | yland 2128  |
| disease resulting Sequer if any, cause. Cause that initial   | inter Cause (Final e or condition ng in death)  Intially list conditions, leading to immediate Enter Underlying (Disease or injury lated events gin death) Last  | b   | consequence of):   | rcoma   |   |  |  |  | Onset and Death 7 YEARS   |
| Sical Ex   |  | d   | . ,  |   |   |  |  |  |   |
| edical   | IAI F  | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown  | pregnancy<br>□ Fetal death 3 □   | Ectopic pregnancy Other (specify)   | ,   |  | 23d. Dat   | te of delive   | nry<br>Day Year   |
| by Physician/Medical   | IALE:  as decedent pregnant the past 12 months?  Yes 2 □ No  | 1 ☐ Live birth 2<br>4 ☐ Pregnant at tir<br>9 ☐ Unknown  | pregnancy<br>□Fetal death 3□<br>me of death 5□   | Other (specify)   |   | 23e. Did to  | obacco use conti   | nth<br>ribute to th  |   |
| Completed by Physician/Medical   | IALE:  as decedent pregnant the past 12 months?  Yes 2 No Unknown  Other significant conditions co   | 1 ☐ Live birth 2<br>4 ☐ Pregnant at tir<br>9 ☐ Unknown  | pregnancy<br>□Fetal death 3□<br>me of death 5□   | Other (specify)   |   | 1 🗀 Y  | Moderate Debacco use control  (es 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | ribute to th   | Day Year  le cause of death?  ably 4 Unknown  psy findings available inpletion of cause of  |
| o Be Completed by Physician/Medical  | ALE:  as decedent pregnant the past 12 months?  Yes 2 No Unknown  Other significant conditions cond | 1 ☐ Live birth 2<br>4 ☐ Pregnant at tir<br>9 ☐ Unknown  | pregnancy<br>□Fetal death 3□<br>me of death 5□<br>not resulting in the u   | Other (specify)   | en in Part I.  26. Place of Death   | 24a. Was autor perfo   | obacco use control obacco use co | ribute to the second order to condeath?  | Day Year lie cause of death? lably 4 Unknown psy findings available inpletion of cause of 2 No  |
| To Be Completed by Physician/Medical Second  | ALE:  (as decedent pregnant the past 12 months?  Yes 2 No Unknown  Other significant conditions comminer?  Yes 2 No  The past 12 months?  The past 12 months?  The past 12 months?  The past 12 months?  The past 12 months 12 mon | 1 Live birth 2 4 Pregnant at tir 9 Unknown  ontributing to death but  Hospital: Propagation  28a. Date of Injury (Month, Day)   | pregnancy Fetal death 3 me of death 5 most resulting in the unit of the second  | Other (specify)   | en in Part I.  26. Place of Deather: 4 \( \text{Nursing Ho} \)  | 24a. Was autor period 1 Yes to (Check only of the control of the c | obacco use control obacco use co | ribute to the surface autoprior to conduct yes.  | Day Year lie cause of death? lably 4 Unknown psy findings available inpletion of cause of 2 No  |
| To Be Completed by Physician/Medical Services Associated by Physician Action 25. Market Services Actio | ALE:  as decedent pregnant the past 12 months?  Yes 2 No Unknown  Other significant conditions cond | 1 Live birth 2 4 Pregnant at tir 9 Unknown ontributing to death but  Hospital: Inpatient 28a. Date of Injury (Month, Day)   | pregnancy Fetal death 3 me of death 5 not resulting in the unit re | other (specify)  Indertying cause give  at 3 □ DOA Other  By 28c. Injury  M 1 □ | en in Part I.  26. Place of Deatt er: 4 □ Nursing Ho y at k? Yes 2 □ No   | 24a. Was autoperforme 5 XX sic 28d. Describe I   | obacco use control obacco use c  | ribute to the stribute to the stribute to the stribute to the stribute to conduct the stribute to the stribute | Day Year  ie cause of death?  ably 4 Unknown  psy findings available  noletion of cause of  2 No  |
| Certification: To Be Completed by Physician/Medical  | ALE:  as decedent pregnant the past 12 months?  Yes 2 No Other significant conditions co | Hospital: upatient  28a. Date of Injury (Month, Day)  | pregnancy Fetal death 3 me of death 5 not resulting in the unit re | other (specify)   | en in Part I.  26. Place of Deather: 4 \( \text{Nursing Ho} \) y at k? Yes 2 \( \text{No} \) ne, date and place,        | 24a. Was autop period 1 Yes in (Check only of the 28d. Describe in City or Toward and due to the   | obacco use control obacco use co | ribute to the stribute to the  | Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  Day Year  |
| edical Certification: To Be Completed by Physician/Medical  Second Secon | ALE:  (as decedent pregnant the past 12 months?  Yes 2 No Unknown  Other significant conditions comminer?  Yes 2 No  The Pending investigation of Death Natural 5 Pending investigation determined  Accident Suicide 6 Could not be determined  Pertifier Medical Examples of the Pending investigation of the determined of the Could not be determined.  | Hospital:  28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  ysician: To the best of Injury:  ysician: To the best of Injury:  On the basis of e | pregnancy Fetal death 3 me of death 5 not resulting in the unit re | other (specify)   | en in Part I.  26. Place of Death er: 4 \sum Nursing Ho y at k? Yes 2 \sum No  ne, date and place, pinion, death occurr | 24a. Was autoperforment of the control of the contr | obacco use control obacco use co | ribute to the stribute to the stribute to the stribute to the stribute to control to con | Day Year  lie cause of death?  ably 4 Unknown  psy findings available inpletion of cause of  2 No  I Route Number,  ated.  the cause(s) |
| Medical Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Part II. 0  25. Wa wa 27. Mar 27. Mar 27. Mar 29b. Si 29b. Si 29b. Si 30. Nar 30 | ALE:  (as decedent pregnant the past 12 months?    Yes 2   No  | Hospital: upatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.  ysician: To the best of and manner state                                     | pregnancy   Fetal death 3   me of death 5     not resulting in the unit of the | other (specify)   | 26. Place of Deather: 4 Nursing Hoyat k? Yes 2 No   | 24a. Was autor performence of the control of the co | obacco use control (es 2 100  an 24b. 1  syring (? 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2   | ribute to the stribute to the stribute to the stribute to the stribute to control to con | Day Year  lie cause of death?  ably 4 Unknown  psy findings available inpletion of cause of  2 No  I Route Number,  ated.  the cause(s) |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 1. Decedent's Name (First, Middle, Last, 2008 Physician Mary len /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution give street and number) Examiner land ALTIMORE asoni Hanco yrs. last birthday) 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours Min 212-26-642 1 ☐ M 2 🛣 F MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 1 ☐ Yes 2 No BALTIMORI **Funeral Director** 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number a O Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Whit Baltimore, Maryland 21215-0036 Specify. Be Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ra 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၀ Tity or Jown, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) lorence E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location/- City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify) 3 □Removal from State BALTIMORE, MI 21. Signa re of Funeral Service Agensee 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tas mon Dr /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Months Probably 2 No 3 Probably 4 No 1 1 ☐ Yes After this certificate has been tuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No dea'h. 2 Accident the within 24 hours after dead To the Funeral Director 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide the Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ms 30. Name and address of pers who completed ause of death (Item 23a) (Type, Print) 6 3508 ROBGRIT 31. Date filed (Month, Day, 32. Registrar's Signature Year)

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  |   | •  | 1 - For<br>State<br>Registrar   | otato or int   | Certificate of Death                    |                             |  |   |   |  | Reg. No. 2008 1186             |                                       |            |  |  |
|--|---|--|---|--|---|-----------------------------|--|---|---|--|--------------------------------|---------------------------------------|------------|--|--|
|  | Dharini   |  | 1. Decedent's Name (First, Middle, Last)  |  |   |                             |  | Date of Death     Month     Day     Year     3. Time of |   |  |                                |                                       |            |  |  |
|  | Physicia<br>/Medic  |  | Guy Terril  | l Milw   | ree                                     |                             |  | <u> </u>  | April   | 8,   | 2008                           |                                       | рMn        |  |  |
| a.   | Examin  | er   | 4a. Facility Name (If not institution, give street and number)  |  |   |                             |  | Location of Death                                       |   | 4c. County of Death                                    |                                |                                       |            |  |  |
| e de la companya de la companya de la companya de la companya de la companya de la companya de la companya de  |   |  | 4490 North Poin 5. Social Security Number   |  | e (In yrs. las                          | t hirthday)                 | Sparrows If Under 1 Year                     | Point If Under 24 Hrs.                                  | 8. Date of Bir  | th Ba  | altimore                       | hplace (State or Fo                   | oreign     |  |  |
|  | Funeral<br>Director   |  | 220-62-1692   | 1 X M 2□ F   | 52                                      | Yrs.                        | Months Days                                  | Hours Min.  | 8. Date of Bir (Month, Da 2/28/                         | 1956<br>1956   | Co                             | ryland                                |            |  |  |
|  | w w   |  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, 7                            | Town or Lo                  | cation                                       |   |   |  |                                | 10d. Inside City L                    | imits      |  |  |
| h with the Maryla<br>23a or 28a-f shov   | ō   | ,  |   |  |   |                             |  |   |   |  | 1 □ Yes 2 <b>]</b>             | ŌNo                                   |            |  |  |
|  | Director  | Maryland Balti 10e. Street and Number  | more  | Spari  | rows_                                   | Point<br>10f. Zip Code      |  |   | 10g. Citi   | zen of What Co   | untry?                         |                                       |            |  |  |
|  |   | 4490 North Poin  | at Blvd   |  |   | 21219                       |  |   | U.  | S. A.  |                                |                                       |            |  |  |
| death  |   | Funeral  | 11. Marital Status  | 12 Was Decedent  | Ever in U.S.                            | 13.                         | Was Decedent of H                            | ispanic Origin? (Span, Mexican, Puerto                  | pecify Yes or No<br>Rican, etc.)                        |  | 14. Race - Ame<br>Black, White |                                       |            |  |  |
| d 21215-0036<br>filed within 72 hours after death with the Maryland<br>Hygiene<br>Wher than "natural", or items 23a or 28a-f show<br>ant, the Mydical Evandry in unit to profitted at  | by Fu   | 1 ☐ Never Married 2 ☐ Marri<br>3 ☐ Widowed 4 ☑ XDivorced   | If Yes, Give  | No   | 1 □Yes 2 □ <b>X</b> No <i>Specify</i> : |                             |  | Specify: White  |   |  | hite                           |                                       |            |  |  |
|  | Completed   | 15. Deceden<br>(Specify only higher  | t's Education<br>st grade completed)  |  | (Give                                   | dent's Usual Occup          | king   | 16b. Kind of Business/Industry                          |   |  |                                |                                       |            |  |  |
|  | ldm   | Elementary/Secondary (0-12)  | College (1-4or 5  |  | _                                       | DO NOT use retired          | •  |   | Fyc:  | evetina  | Contract                       | tor                                   |            |  |  |
|  | e filed v<br>Il Hygie<br>other i  | ပိ   | 12<br>17. Father's Name (First, Middle,   | Last)  |   | Owner                       | / Operat                                     | 18. Mother's Nam  | ne (First, Middle                                       |  |                                | Contract                              | <u>.01</u> |  |  |
| an   | id be<br>lental<br>ked c<br>ic eve  | To Be  | Robert Blair Mi   | lwee .Tr   |   |                             |  | Katheri   | ne Fran   | rances Kidd  |                                |                                       |            |  |  |
| Ore, Maryland 2. es 1 and 2 should be filed w of Health and Mental Hygie filem 27 is marked other t  |   | 19a. Informant's Name/Relations  | hip (Type. Print) (Mo+1   | or)  | 19b. Mailir                             | ng Address (Street          | and Number or Ru                             | ıral Route Numb   | er, City o  | r Town, State, 2                                       | Zip Code)                      |                                       |            |  |  |
|  | and 2<br>ealth<br>n 27 i  |  | Katherine Franc   | es Milwee  |   |                             | 8 Easterr                                    |   |   |  |                                |                                       | 220        |  |  |
| ore  | ges 1<br>It of Hi<br>If iten<br>or oth  |  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation   | 3 ☐ Removal from State   | 20b. Plac                               | ce of Dispo<br>netery, crer | sition (Name of<br>matory or other plac      | e) 1/9  | Date  | 20c. Lo  | cation - City or               | Town, State                           |            |  |  |
|  | t. Pages<br>tment of<br>tant: If it<br>ijury or o   |  | 4 ☐ Donation 5 ☐ Other (S   | specify)   | Bay                                     |                             | Crematory                                    |   | 8   | Bal  | timore                         | City, MD                              |            |  |  |
| Ba   | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.                        |  | 21. Signature of Funeral Service  | Licensee   |   |                             | 2. Name and Addre<br>Sruzdzinsl<br>407 Old I |   | 1 Home  | PA   | v Maru                         | land 2123                             | 21         |  |  |
|  |   |  | 23a. Part 1. Enter the disease, or  | complications that cause   | d the death.                            |                             |  |   |   |  | A, Mary                        | Approximate<br>Interval Between       | en         |  |  |
| , ,  | Physician   | 0 1  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  |  |   |                             |  |   |   |  | Onset and Death                |                                       |            |  |  |
|  | /Medical  |  | disease or condition resulting in death)  | a. Due to (or as   |   |                             | ic care                                      | OUSCH   | 1001 10   |  |                                |                                       |            |  |  |
|  | Examiner  |  | Sequentially list conditions  | b  |   |                             |  |   |   |  |                                |                                       |            |  |  |
|  | sit ed  | Examiner   | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as  | à consequel                             | ice of).                    |  |   |   |  |                                |                                       |            |  |  |
| 30   | xecute<br>and<br>I-trans  | хаш  | Cause (Disease or injury that initiated events c.  resulting in death) Last  Due to (or as a consequence of):   |  |   |                             |  |   |   |  |                                | <u> </u>                              |            |  |  |
| 68760, ප   | rtificate be executed<br>ng physician and<br>sas the burial-transit                             | Medical E  |   |  |   |                             |  |   |   |  |                                |                                       |            |  |  |
| 289  | tificate<br>g phy<br>as the   |  |   | d.   |   |                             |  |   |   |  |                                | s = -230 =                            |            |  |  |
| Вох  | eath cer<br>attendin<br>for use   |  | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   |   |                             | ☐ Ectopic pregnanc                           | :v  |   | 23d. Date of delivery  Month Day Year                  |                                |                                       | or         |  |  |
| О  | law requires that the death ce<br>as been signed by the attendi<br>2 should be detached for use | Physician/   | in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) |   |                             |  |   |   |  | Month                          | Day Yea                               | 11         |  |  |
| <u>o.</u>  | uires that the de<br>signed by the a<br>d be detached fi  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                             |  |   | 23e. Did  | 23e. Did tobacco use contribute to the cause of death? |                                |                                       |            |  |  |
| Records,   | quires<br>an sign<br>ald be   | ed by  |   |  |   |                             |  |   | 1)2   | 1 Yes 2 No 3 Probably 4 Unknown                        |                                |                                       |            |  |  |
| 000  | aw rec<br>Is bee<br>2 shou  | s should standard to the stand |   |  |   |                             |  |   | 24b. Were autopsy findings availa                       |  |                                |                                       |            |  |  |
| Υ.   | The la<br>ate ha  | 24a. Was an autopsy performed? 1 □ Yes 2 ◯ No.   |   |  |   |                             |  |   |   |  |                                |                                       |            |  |  |
| Vital  | sician: The law<br>certificate has t<br>irector, page 2 s                                       | Be C   | 25. Was case referred to medical 26. Place of Death (Check only one)  |  |   |                             |  |   |   |  |                                | · · · · · · · · · · · · · · · · · · · |            |  |  |
| 7  | Physic<br>rthis corral dire   | မ  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify)   |  |   |                             |  |   |   |  |                                |                                       |            |  |  |
| n<br>C   | ding Phys<br>h.<br>After this<br>funeral di   | ion:   | Natural 5 ☐ Pending (Month, Day, Year) Injury Work?   |  |   |                             |  |   | 28d. Describe   | 28d. Describe how injury occurred                      |                                |                                       |            |  |  |
| 2 HAccident Investigation of Section 1 Section |   |  |   |  |   |                             |  | 100 2 100   | 28f. Location (Street and Number or Rural Route Number, |  |                                |                                       |            |  |  |
| <u> </u>   | alor/<br>after<br>Dire  | erti   | 4 Homicide determined building, etc. (Specify)  |  |   |                             |  |   |   | City or Town, State)                                   |                                |                                       |            |  |  |
|  | To the Hospital or within 24 hours after To the Funeral Directory filled in b                   |  | 29a. Certifier (Check only (Check only  29a Certifier (Check only  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) |  |   |                             |  |   |   |  |                                |                                       |            |  |  |
|  | To the h<br>within 2<br>To the F<br>complet   | Medical  | one) and manner stated.  29b. Signature and title of gertifier 29c. License number  |  |   |                             |  |   |   | 29d. Date signed (Month, Day, Year)                    |                                |                                       |            |  |  |
|  | F 3 F 8   |  | The head (  | /1 GM  | _ 1                                     |                             | 018  |   |   | A  | 1                              |                                       |            |  |  |
|  |   |  | 30 Name and address of person   | who completed cause of   | death (Item 2                           | Ba) (Type.                  |  | 64/   |   | 1,10   | 7,17                           | ,2008<br>,093                         |            |  |  |
|  | 10  |  | Philip Mil.   | tello Mi   | 675                                     | imbl                        | le Hill                                      | CT 64 71  | Hen vill  | 10   | 19 SI                          | ,093                                  |            |  |  |
|  | Sta<br>Registr  |  | 31. Date filed (Month) Day, Year)  APR 1 1  | 2008 . Regist  | rar's Signatur                          | April 1                     | de   |   |   | •  |                                |                                       |            |  |  |

DHMH 17 Rev 1/2001

08-02676 William Morton

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 'illiam Morton  | 1-             | State of Maryland / Department of He For State Certificate of De   | ealth and Mental Hy<br>e <i>ath</i>                                    |                         | eg. No.                      | 2008 1186  |
|---|----------------|--|--|-------------------------|------------------------------|--|
| Physician/  |                | gistrar Decedent's Name (First, Middle,Last)   |  | 2. Date of Dea<br>Month | th                           | 3. Time of Death   |
| ledical Examine   |                | William Morton   |  | April 5, 20             | 008                          | 11431115   |
|   | 48             | and delity reality reality and the second  | ity, Town, or Location of Death  |                         | 4c. Coun                     | ty of Death  |
| Funeral<br>Director   | 5.             | Social Security Number 5 6. Sex 7. Age (In yrs. last birthday) If  | Under 1 Year If Under 24Hrs. fonths Days Hours Min.                    | 8. Date of Bi           |                              | YY) 9. Birthplace (State or Foreign Md. Country)   |
| Bilector  | <u> </u>       | 214- <del>56-7048</del> 1 M 2 F 58 Yrs.  |  |                         |                              |  |
| any   | _              | Da. State 10b. County 10c. City, Town or Location  |  |                         |                              | 10d. Inside City Limits  |
| <b>₹</b>  |                | id. Baltimore  | e  |                         |                              | 1 X Yes 2 No   |
| the Maryland<br>a or 28a-f show<br>tified at once.  | 1              | De. Street and Number  | f. Zip Code  |                         |                              | What Country?  |
| th the Maryland 23a or 28a-f sho notified at once.  |                | 1102 West Harlem Avenue  | 21217<br>ecedent of Hispanic Origin? ( Sp                              | ocify Ves or N          | U.S.F                        | ace - American Indian, Black,  |
| or items  | 1              | Never Married 2 Married Armed Forces? If Yes, s  | s 2 X No specify:  | Rican, etc.)            | Speci                        | hite, etc.   |
| s afte  | 3              | or Dates:  15. December 5. Education (Specify only highest grade completed) 16a. December 5.   | Jsual Occupation (Give kind of v                                       | vork done               | 16b. Kind o                  | f Business/Industry  |
| 5-0036  I of within 72 hours after the within 72 hours after other than "natural", the Medical Examiner   |                | Elementary/Secondary (0-12) College (1-4 or 5+)  | of working life. DO NOT use reti                                       | red)                    | Mai                          | intenance  |
| 136<br>Tthin 7<br>Than<br>edical  |                | 12 Gro   | unds Keeper  |                         |                              | - 1233 10  |
| 15-0036 filed within 72 Hygiene do other than 's, the Medical   |                | 7. Father's Name (First, Middle, Last)   | 18.Mother's Name   |                         | Maiden Surna<br>Collin       |  |
|   |                | William B. Morton  9a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Ac  | ddress (Street and Number or I   |                         |                              |  |
| , MD 2121 and 2 should be fi tealth and Mental   tem 27 is marked traumatic event,  | - 1            | od: Illioniance realistic for the second sec | toney Ridge Rd.  |                         |                              | The state of the s |
| nore, MD 2 gges 1 and 2 shou nt of Health and h t: If item 27 is r other traumatic  | 11-            | 20h Place of Disposition   | Name of cemetery   | Date                    | 20c. Locat                   | ion - City or Town, State  |
| Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to  |                | 1 X Burial 2 Cremation 3 X Removal from State crematory or other   | e Ceme. 04/1   | 2/2008                  | Clove                        | er, Virginia   |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oth   | - 1            |  | e and Address of Facilithe   | Derric                  | k C. Jo                      | ones F/H, P.A.   |
| Dep Dep Inju  |                | 461  | 1 Park Hots. Av  | ze. Ba                  | ltimore                      | e. Maryland 21215  |
| Physician   | 7              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  | mode of dying, such as cardiac   | or respiratory a        | rrest, shock, o              | Between Onset and  Death   |
| aminer  |                | mmediate Cause (Final disease a. Intracranial Hemorrhage   |  |                         |                              | Dodai  |
|   | 1              | or condition resulting in death)  Due to (or as a consequence of):  b. Hypertensive Cardiovascular Disease   | 9  |                         |                              |  |
|   |                | ref any, leading to immediate Due to (or as a consequence of):   |  |                         |                              |  |
|   | Ę١             | cause. Enter Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):  |  |                         |                              |  |
| d d ansit   | Ĭ              | events resulting in death) Last  d.  |  |                         |                              |  |
| te be executed ysician and burial - transit   | edical         | UNPENDED AMENDED 5 per fh g878 4-  | -18-08 vt  |                         |                              |  |
| Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death.  In Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burnel of the funeral director. | ĕ,             | F FEMALE: 23c. If yes, outcome of pregnancy  |  | 20001                   | 23d. Da<br>Mor               | ate of delivery<br>onth Day Year   |
| Records, P.O. Box 68760. The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the page 2 should be detached for use as the base.  | Physician/M    | past 12 months?  | death 3 Ectopic pregr<br>r (Specify)                                   | iancy                   | l Wor                        | iui buy .cs.   |
| 30x<br>death of   | Sic            | 1 Yes 2 No 9 Unknown 9 Unknown   |  |                         |                              |  |
| O. E  |                | Part II. Other significant conditions contributing to death but not resulting in the unc   | derlying cause given in Part I.  |                         |                              | contribute to the cause of death?  3 Probably 4 V Unknown  |
| P Signed Signed be de   | g<br>S         |  |  | 24a. W                  | Yes 2 No                     | 24b. Were autopsy findings available   |
| ords<br>v requisionals  | Completed      |  |  | au                      | as an intopsy erformed?      | prior to completion of cause of death?   |
| ecc<br>he lav<br>ate ha   | Ĕ              |  |  | 1 <b>Y</b> Ye           | s 2 No                       | 1 Yes 2 No   |
| al R  | ψ              | 25. Was case referred to medical   | 26.Place of Death (Chec  |                         | 7                            | 0 00   |
| of Vital Records ing Physician: The law requi   |                | examiner?  1 V Yes 2 No  28 Date of Injury  28b, Time of Injury  28b, Time of Injury   | 3 DOA 4 Hars   | ing Home 5              | Residence                    |  |
| n of<br>ling P  | ٳۼ             | (Month, Day, Year)   | 1 Yes 2 No   | 200, 2000               | eo men maery                 |  |
| IVISIOF<br>or Attend<br>after death<br>Director:  | läi<br>läi     | 2 Accident Investigation 28e. Place of Injury - At home, farm, street  | 4,5  | 28f. Location           | n (Street and                | Number or Rural Route Number, City   |
| Divis   | Certification: | 3 Suicide 6 Could not be determined (Specify)  |  | or Tow                  | n, State)                    |  |
| the Hospi   | Medical Ce     | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (check only one) 2 Medical Examiner: On the basis of examination and/or investigation  | ed at the time, date and place, a<br>on, in my opinion, death occurred | nd due to the o         | cause(s) and mate and place, | nanner as stated. and due to the cause(s)  |
| X , Figure 1  | Mec            | and manner stated.  29b. Signature and title of certifier  | 29c. License number  |                         | 29d. Dat                     | e signed (Month, Day, Year)  |
|   |                | Canal Hallan   | O.C.M.E.   |                         | April 6                      | 5, 2008  |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn S  | treet, Baltimore, MD 212   | 201                     |                              |  |
| Sta   |                | 31. Date filed (Month, Day, Year) 32 Registrar's Signature   |  |                         |                              |  |
| Regist  | αľ             | Lin all appropriate the second   |  |                         |                              |  |

|           |   |              | For State  |                    | State                        | of Ma                      | ryland                  |                            |                                      |   |                      | and M      | ental Hy                            | •                      | 0               | 000                   |   |                         |
|-----------|---|--------------|--|--------------------|------------------------------|----------------------------|-------------------------|----------------------------|--------------------------------------|---|----------------------|------------|-------------------------------------|------------------------|-----------------|-----------------------|---|-------------------------|
|           |   |              | Registrar  1. Decedent's Name (First, Mid  | dla i as           | et)                          |                            |                         | Cei                        | unca                                 | te of L                                 | Jeain                | —-т        | 2. Date of De                       | Reg. No                | o               | JUE                   | 3. Time o                               | B b                     |
|           | Physicia  | an           |  |                    | 51/                          |                            |                         |                            |                                      |   |                      |            |                                     | Month Day Year         |                 |                       |   |                         |
|           | /Medic  |              | Max Mitchel  4a. Facility Name (If not instituti   |                    | street and n                 | umber)                     |                         |                            | 4b. City, Town, or Location of Death |   |                      |            | 7                                   | 1                      |                 | of Death              | 3:40                                    | A                       |
| J         | Examin  | er           | Union Memori   |                    |                              |                            |                         |                            | 15. 01.)                             | , |                      |            | 1211                                | "                      | . Godiny        | OI BOULI              |   |                         |
|           | Funeral   |              | Social Security Number   | 6. S               |                              | _                          | (In yrs. la             | st birthday)               |                                      | er 1 Year                               | If Under 2           |            | 8. Date of Bi                       | irth                   | ,               | 9. Birthp             | olace (State                            | or Foreign              |
|           | Director  |              | 218-36-7160  | 1                  | <b>⊠</b> M 2□F               |                            | 66                      | Yrs.                       | Months                               | Days                                    | Hours                | Min.       | (Month, Di                          | ay, rear<br>13/1       |                 | Coui<br>TN            | ntry)                                   |                         |
|           | D.  |              | Usual Residence of Decedent  |                    |                              |                            | 10.01                   |                            |                                      |   |                      |            | V4./                                | 10/1                   | -736            |                       |   |                         |
|           | arylar<br>show<br>d at  | -            | 10a. State 10b. Coun   | y                  |                              |                            | 10c. City,              | Town or Lo                 | cation                               |   |                      |            |                                     |                        |                 | 1                     | 10d. Inside (                           | City Limits<br>≥ 2 No   |
|           | he Mi<br>18a-f  | Director     |  | Ltim               | ore                          |                            | Es                      | sex                        |                                      |   |                      |            |                                     |                        |                 |                       |   | 2 2 200                 |
|           | with t  | ä            | 10e. Street and Number   |                    |                              |                            |                         |                            | 10f. Z                               | p Code                                  |                      |            |                                     | 10g. Ci                | itizen of \     | What Cou              | ntry?                                   |                         |
|           | eath<br>is 23   | Funeral      | 346 Wye Road   |                    | 12. Was De                   | andont E                   | vor in II C             | 140                        |                                      | 21221                                   |                      | -i=2 (C= - | sif. Vac as \$1                     |                        | SA<br>14 Pag    | o Amoria              | can Indian,                             |                         |
| _         | ter d   | 'n           | 11. Marital Status 1 □ Never Married 2 Ma  | rried              | Armed F                      | Forces?                    |                         | 13.                        | f Yes, sp                            | ecify Cuba                              | n, Mexican           | , Puerto I | cify Yes or Ne<br>Rican, etc.)      | 0-                     |                 | k, White,             |   |                         |
| 33        | hours after death with the Maryland<br>tural", or items 23a or 28a-f show<br>al Examiner must be notified at  | by I         | 3 ☐ Widowed 4 ☐ Divorce  |                    | Is Van C                     | aive<br>Dates: \           |                         | 59                         | 1 🗌 Yes                              | 2ENo                                    | Specify:             |            |                                     |                        | Specify         |                       | ite                                     |                         |
| 215-0036  | d within 72 hours after death with the Marylan<br>glene.<br>It than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at | ted          | 15. Decede   | nt's Ed            | lucation                     | ·                          | - 1                     | 16a. Dece                  | lent's Us                            | ual Occupa                              | ation                |            |                                     | 16b. H                 | Kind of Bu      | usiness/In            |   |                         |
|           | within 72<br>ene.<br>than "nai<br>he Medica   | Completed    | (Specify only high<br>Elementary/Secondary (0-12)  |                    | <del></del>                  | (1-4or 5+                  | )                       | life.                      | DO NOT                               | ork done d<br>use retired               | luring most<br>)     | of workii  | ng                                  | A.                     | utom            | otive                 | <b>=</b>                                |                         |
| N.        | filed wil<br>Hygien<br>other th   | Son          | 12   | $\bot$             |                              |                            |                         | Mec                        | hani                                 | <b>z</b>                                |                      |            |                                     | <u></u>                |                 |                       |   |                         |
| and       | be filk<br>tal Hy<br>doth<br>event  | Be (         | 17. Father's Name (First, Middle   | e, Last)           |                              |                            |                         |                            |                                      |   | 18. Mothe            | r's Name   | (First, Middle                      | e, Maidei              | n Surnan        | ne)                   |   |                         |
| >         | should be filed vand Mental Hygie<br>s marked other t<br>umatic event, th   | 은            | John Ray Mit   |                    |                              |                            |                         | _                          |                                      |   |                      |            | ice All                             |                        |                 |                       |   |                         |
| ===       | C1 (0 = 10  |              | 19a. Informant's Name/Relation   |                    |                              |                            |                         | 19b. Mailir                | ng Addres                            | s (Street a                             | and Numbe            | r or Rura  | l Route Numl                        | ber, City              | or Town,        | State, Zip            | Code)                                   |                         |
|           | 1 and<br>Health<br>Sm 27<br>ther tr   |              | Eva Kay Mitch<br>20a. Method of Disposition  | ell                | Wife                         |                            | 20h Pla                 | 346<br>ace of Dispo        |                                      |   | i Esse               |            | 4D 2122                             | 1                      | agation         | City or T             | Ctata                                   |                         |
| altimore, | Pages<br>nent of I<br>nt: If it   |              | 1 Burial 2 Cremation   |                    |                              | n State                    | 1 00                    | motory ora                 | mataniar                             | ather alee                              | e) (O                |            |                                     |                        |                 |                       | own, State                              |                         |
|           | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |              | 4 □ Donation 5 □ Other 21. Signature of Funeral Service  |                    |                              |                            | Cì                      | hesape                     | ake                                  | Crema                                   | s tory               | Inc        |                                     | В                      | eltsv           | rille                 | Mary                                    | Land                    |
| 4         | hysician  |              | 23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) | or comp<br>st only | plications that one cause on | each line                  | he death.               | Do not ent                 | <b>8717</b><br>er the mo             | Gree<br>de of dyin                      | n Pasi<br>g, such as | cardiac o  | al Alte<br>Drive<br>r respiratory a | Bal                    |                 |                       | Arylan Approxima Interval Be Onset and  | ate<br>etween<br>Death  |
| -         | /Medical<br>Examiner  |              | resulting in death)  |                    |                              | o (or as a                 |                         | 1                          | ,                                    |   |                      |            |                                     |                        |                 |                       | 1.7                                     | ,                       |
|           |   | <u></u>      | Sequentially list conditions,  |                    | b. ear                       | o (or as a                 | 0691                    | c she                      | ck                                   |   |                      |            |                                     |                        |                 |                       | 4 wee                                   | eks                     |
| 5         | ned<br>nsit   | Examiner     | day, leading to inmediate cause. Enter Underlying Cause (Disease or injury   | <                  |                              | ,                          |                         | ,                          | 101                                  | 0.12                                    |                      |            |                                     |                        |                 |                       | 26/640                                  | e/                      |
| ,         | execu<br>n and<br>ial-tra   | Exai         | that initiated events<br>resulting in death) Last  |                    | c. Due to                    | o (or as a                 | conseque                | ence of):                  | 1640                                 | 11/1                                    |                      |            |                                     |                        |                 |                       | 2616 40                                 | 24                      |
| 8/60,     | cate be executed<br>physician and<br>the burial-transit   | dical        |  | l                  | -d                           |                            |                         |                            |                                      |   |                      |            |                                     |                        |                 |                       |   |                         |
| 9         | tificat<br>ng phy<br>as th  | Medi         |  |                    |                              |                            |                         |                            |                                      |   |                      |            |                                     |                        |                 |                       |   |                         |
| C. Box    | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit             | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                    | 9                  |                              | birth 2<br>gnant at t      | Fetal                   | death 3 [                  | Ectopic  <br>Other (s                | pregnancy<br>specify)                   |                      |            |                                     |                        |                 | te of deliventh       | ery<br>Day                              | Year                    |
| J         | that<br>ned by<br>deta  |              | Part II. Other significant condi   | tions o            | ontributing to               | death but                  | not resul               | ting in the u              | nderlying                            | cause give                              | en in Part I.        |            | 23e. Did                            | tobacco                | use cont        | ribute to t           | he cause of                             | death?                  |
| Hecords   | w requires<br>been sign<br>should be  | ted by       |  |                    |                              |                            |                         |                            |                                      |   |                      |            | 10                                  | Yes 2                  | 2□ No           | 3 ☐ Prof              | bably 4 □                               | ]Unknown                |
| Hec       | The law<br>ate has b<br>page 2 sl   | Completed    |  |                    |                              |                            |                         | · · · · ·                  |                                      |   |                      |            | 24a. Was<br>auto<br>perf<br>1□ Yes  | opsy<br>formed?        |                 | prior to co<br>death? | opsy findings<br>impletion of<br>2 4 No | s available<br>cause of |
| Vital     | Physician:<br>this certific<br>ral director,  | Be           | 25. Was case referred to medic examiner?   | al                 | Hospital:                    |                            |                         |                            |                                      | Othe                                    | )F:                  |            | (Check only                         |                        |                 |                       |   |                         |
| ō         | ج تقیف  | £ .          | 1 Yes 2 No   | 1                  | 1 5                          | Inpatien<br>e of Injury    |                         | R/Outpatier<br>28b. Time o |                                      | OA                                      | 4 LI NU              |            | ne 5 Res                            |                        |                 |                       | fy)                                     |                         |
| 0         | ding P  | cation:      | 1 Natural 5 □ Pend   | ing<br>tigation    | (Mo                          | onth, Day                  | Year)                   | Injury                     | м                                    | 28c. Injury<br>Work                     | (?ີ່<br>Yes 2 ∐ l    |            | .ou. Describe                       | now mje                | ary occur       | i eu                  |   |                         |
| DIVISION  | To the Hospital or Attending Pl<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral           | Certifica    | 3 Suicide 6 Coul   |                    | 28e. Plac                    | ce of injur<br>Iding, etc. | y - At hon<br>(Specify) | ne, farm, str              | eet, facto                           | _                                       | _                    |            | 28f. Location<br>City or To         | (Street a<br>own, Stai | and Numb<br>te) | er or Run             | al Route Nu                             | mber,                   |
|           | e Hospit<br>24 hours<br>e Funers<br>etely fille   | edical (     | 29a. Certifier 1 Certify (Check only one) 2 Medica   | ing Ph             | ysiclan: To the              | basis of e                 | examinati               | on and/or in               | vestigatio                           | n, in my o                              | pinion, dea          | th occurr  | ed at the time                      | e, date ar             | nd place.       | and due t             | to the cause                            | (s)                     |
|           | To th<br>within<br>To th  | Me           | 29b. Signature and title of certif   | ier                | 1                            |                            |                         |                            | 25                                   | 9c. License                             | number               |            |                                     | 29d. Da                | ate signe       | d (Month,             | Day, Year)                              |                         |
|           |   |              | MILL   |                    |                              |                            |                         |                            | A                                    | T24.                                    | 3899                 | 16 H       | 37                                  | 4/                     | 106             | 10                    | 8                                       |                         |
|           | 241   |              | 30. Name and address of person   | A .                | completed cau                | use of dea                 | ath (Item :             | 23a) (Type,                | Print)                               | » \ \ \                                 | 1.0 m                | or.        | 37<br>19/ Ho                        | > 1 A1                 | +a/             |                       | 10                                      |                         |
|           | Sta<br>Registr  |              | 31. Date filed (Month, Day, Yea APR 1 1  | r)                 | 18                           | Registrar                  | 's Signatu              | ure Ana                    | 2000                                 |   | 100                  |            |                                     |                        |                 |                       |   |                         |
|           |   |              |  |                    | 100                          |                            | 20                      | 15713                      | -                                    |   |                      |            |                                     |                        |                 |                       |   |                         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Reg. No. State of Maryland / Department of Health and Mental Hygiene Cartificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NATALIE MACBLANE APRIL 6 2008 12:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD 8. Date of Birth (Month, Day, Year) 10-18-1914 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 □ M 2 🗓 F Days Hours 215-16-1377 93 Director Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director XXYes ZXI Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 207 Kings Crossing Circle 21014 Unit 2A U.S.A. Examiner must Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant marked other 17. Father's Name (First, Middle, Last)
Sofinowski
Frank Setinowski 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever Pages 1 and 2 should be nent of Health and Mental Katherine Brodowski ပ 19a. Informant's Name/Relationship (Type. Print) 207 Kings Crossing Cir., Unit 2A Bel Air, MD 21014 Myrna Scherer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Luth. Cemetery 04-09-2008 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Buan Gil Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** La zern /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or inju that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician that the death certificate be Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death Day 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 autopsy certificate ! perform 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

death.

Funeral Director: stely filled in by the hours after Hospital 24

3 ☐ Suicide 4 ☐ Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D32295

7,2000 Opec: )

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID DUNN - 615 WEST MACPHAIL ROAD - BEL AIR, MD 21014 31. Date filed (Month, Day, Year)

State Registrar

Medical

2008 APR 11



the

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (\_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9<sup>Day</sup> APRIL **Physician** 2008 8:45 pm NANCY ISELIN MARBURG /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 101 CHARLESBROOKE RD. BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/23/1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗌 M PENNSYLVANIA 220-46-6295 88 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE CHARLESBROOKE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 2 101 CHARLESBROOKE RD. 21212 USA death v Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2X No Specify: WHITE þ 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the More. HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. OLIVER ISELIN JR. ELIZABETH BROWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33455 6322 S.E. MORNING DOVE WAY HOBE Sound, FL. ANNE M. WIEDENMAYER(DAUGHT.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 04/11/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Vaxuelos Orse Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No Hospital: 은 1 🔲 Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, d in by the within 24 hours aft

To the Funeral Di

completely filled in

Baltimore, Maryland 21215-0036

27. Manner of Death 1/2 Natural 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Tyes 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

and manner stated

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

ICLEHART III M.D. 6301 N. CHARLES ST. BALTO., MD. 21212. IREDELL W.

State Registrar

Medical

29a, Certifier

31. Date filed (Month, Day, Year) 2008 **APR 11** 



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #22 Peratem ( Asys land 1/10 Bartment of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 7:30 AM 4a. Facility Name (If not institution, give street and number) Mettle 2008 /Medical 0 4b. City, Town, or Location of Death 4c. County of Death Examiner Dak Crest Village Care
Social Security Number 6. Sex 7. Age rkuille If Under 24 Hrs. Center altimore 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☐ M 2 🗷 F Months Days Hours 9 215-05-6576 Director Marylano Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10d. Inside City Limits 1 ☐ Yes 2 M No Director Parkvill MD altimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA BIVD 8834 Walther 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify. þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Daltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ္ရ 19a. Informant's Name/Relationship (Type. Print) Air Maryland 21014 Carole M. Warrell-daughter 800 Dominion Drive Bel 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel of Crematon Services Dellar Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-11-08 Forest Hill, Maryland + Cremation Services - Parkville Parkville MD 21234 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not 8800 mHatt or dcRDcardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jementio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesee or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ brain cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1∐ Yes 2 NO **Division or Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q Blud 8800 03/15 Nalther 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2008 1 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month APR 7<sup>Day</sup> 2008<sup>Year</sup> MARJORIE L.C.MAGUIRE 9:43 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🕅 F Yrs. Director 92 143-16-8707 July 22, 1915 Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23a or. Funeral 4111 Wexford Drive 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1961–1975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Completed by Specify: 3 Widowed 4 ☐ Divorced White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Albert Christy Emma Bell Gould 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Maguire / Daughter-In-Law 13917 Paradise Church Road, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 16. 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2008 Arlington, Virginia 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3 M01473 23a. Par 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2 XNo 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No certificate has b 24a. Was an autopsy perform 2 No 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) nours after death. neral Director: After this ce y filled in by the funeral direc Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 🔲 Inpatient 2X ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

20+1

State

TINIKA A. MONTGOMERY 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 1 2008

Registrar

29c. License number

0101243122 (VA)

29d. Date signed (Month, Day, Year) 04/67/2008

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

|             |  |               | For State  | State of Maryland  |  | rtment of F<br>ctificate of t            |  |                                       | iene<br><sub>eg. No.</sub> 2 | nac                           | 1100  |
|-------------|--|---------------|--|--|--|--|--|---------------------------------------|------------------------------|-------------------------------|---|
|             |  |               | Registrar  1. Decedent's Name (First, Middle, Last)  |  |  |  |  | 2. Date of Deat                       | - 6.00                       | UUC                           | 3. Time of Death                              |
|             | Physici  | an            | John Dietrich Me   |  |  |  |  | Month                                 | 3, <sup>□</sup> 200          | 8 Year                        | 10:00 A.M                                     |
|             | /Medio   |               | 4a. Facility Name (If not institution, give s  |  |  | 4h City Town or                          | r Location of Deat                       | -1                                    |                              | nty of Death                  |   |
|             | Examir   | ner           | 11800 Coldstream   | · ·  |  | Potomac                                  | Location of Boat                         |                                       |                              | tgome                         |   |
|             | Funeral  |               | 5. Social Security Number 6. Sex   |  | ast birthday)  | If Under 1 Year                          | If Under 24 Hrs                          | 8. Date of Birth                      |                              | 9. Birth                      | place (State or Foreign                       |
|             | Director   |               | 578-48-0842 1X   | M 2□F 71   | Yrs.   | Months Days                              | Hours Min.                               | Jan. T                                | , " <sup>ea</sup> " 193      | 7 Mary                        | Tand  |
| _           | ס  |               | Usual Residence of Decedent  |  |  |  | <u> </u>                                 |                                       |                              |                               |   |
|             | rylan<br>show  | _             | 10a. State 10b. County   | _ '  | , Town or Lo   | cation                                   |  |                                       |                              |                               | 10d. Inside City Limits                       |
|             | Ba-f s   | 양             | Maryland Montgome  | ry Po  | tomac  |  |  |                                       |                              |                               | 1 ☐ Yes 2 🕱 No                                |
|             | or 28  | Director      | 10e. Street and Number   | - •  |  | 10f, Zip Code                            |  | 1                                     | •                            | of What Cou                   |   |
|             | be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or Items 23a or 28e-f show event, the Medical Eventiner must be notified at | 2             | 11800 Coldstream   | Drive  |  | 20854                                    |  |                                       |                              | d Sta                         |   |
|             | tems   | Funeral       | T. Mariai States   | 12. Was Decedent Ever in U.S<br>Armed Forces?                  | S. 13. V   | Was Decedent of H<br>f Yes, specify Cuba | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No-<br>to Rican, etc.) |                              | Race - Ameri<br>Black, White, |   |
| 30          | or l   | by F          | 1 Never Married 2 Married  | 1 ☐ Yes 2 No<br>If Yes, Give                                   | 1  | I□Yes 2√Wo                               | Specify:                                 |                                       | Spe                          | ecify: Wh:                    | i te  |
| 9500-61212  | hours<br>ural  | 교<br>교        | 3 Widowed 4 Divorced   | Year or Dates:   |  | ient's Usual Occup                       | ation                                    |                                       | 16h Kind o                   | f Business/Ir                 |   |
| က်          | "nal   | Completed     | 15. Decedent's Educ<br>(Specify only highest grade   | e completed)   | (Give  | kind of work done of NOT use retired     | during most of wo                        | rking                                 | TOD. KING O                  | i Dusiness/ii                 | idustry                                       |
| 7           | within iene.   | E C           | Elementary/Secondary (0-12)  | College (1-4or 5+)   |  | 1 Engine                                 | •  |                                       | Engin                        | eering                        | g Firm  |
|             | filed y<br>Hygi<br>other   | ပိ            | 17. Father's Name (First, Middle, Last)  |  | 0111   | 2 21.52.10                               | 18. Mother's Na                          | me (First, Middle, I                  | Maiden Suri                  |                               | 2   |
| <u>a</u>    | Mental  <br>Mental  <br>arked o  | To Be         | Charles Randolph   | Mengers  |  |  | Cora Ma                                  | rvin Gosl                             | line                         |                               |   |
| Maryland    | should be<br>and Menta<br>s marked<br>umatic ev  | -             | 19a. Informant's Name/Relationship (Type   | pe. Print)   | 19b. Mailin  | g Address (Street                        | and Number or R                          | ural Route Number                     | r, City or To                | wn, State, Zi                 | ip Code)                                      |
|             | and 2:<br>ealth a<br>m 27 is<br>her trau   | 1             | Susan A. Mengers   | / Wife   | 11800  | Coldstr                                  | eam Dr.,                                 | Potomac                               | Mary                         | land :                        | 20854   |
| စ်          | - T 5 =  |               | 20a. Method of Disposition   |  | lace of Dispo  | sition (Name of<br>natory or other place | 201                                      | Date                                  | 20c. Location                | on - City or T                | own, State                                    |
| e<br>E      | Pages<br>nent of<br>int: If its<br>iry or o  |               | 1 ☐ Burial 2 🙀 Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Othe <u>r (Specify)</u>                                   | emoval from State  | gomerv (   | rematorium                               | Tnc. Apri                                | 1 11, 2008 F                          | 3ethes                       | sda, M                        | aryland                                       |
| Baitimore,  | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |               | 21. Signature of Funeral * rvice Lines   |  | The state of the s |  |  | al Home/Bet                           |                              |                               |   |
| ñ           | Dep<br>lmp   | ŀ             | 1200   |  |  |  |  | , Bethes                              |                              |                               |   |
|             |  |               | 23a. Part 1. Enjer the disease, or complishock, or heart failure. List only or                               | cations that caused the death                                  |  |  |  |                                       |                              |                               | Approximate<br>Interval Between               |
|             | Physician  |               | Immediate Cause IF nal   | Cerebrovascu   |  |  |  |                                       |                              |                               | Onset and Death 10 Years                      |
|             | /Medical   |               | disease or condition resulting in death)   | Due to (or as a consequ  |  | LSCase                                   |  |                                       |                              |                               | 10 10015                                      |
| A.          | Examiner   | ı             |  | Hypertension   |  |  |  |                                       |                              |                               | 10 Years                                      |
|             |  | ē             | Sequentially list conditions, if any, leading to immediate cause. Line, funderlying Cause (Disease or injury | Due to (or as a consequ  |  |  |  |                                       |                              |                               |   |
| ۶.          | ficate be executed<br>physician and<br>s the burial-transit  | Examin        | that initiated events  | Hyperlipidem   | nia  |  |  |                                       |                              |                               | 10 Years                                      |
| Ď,          | e exe<br>an ar<br>rrial-t  |               | resulting in death) Last   | Due to (or as a consequ  | ence of):  |  |  |                                       |                              |                               |   |
| 38/60,      | ate be<br>nysici<br>ne bu  | dical         |  | J  |  |  |  |                                       |                              |                               |   |
| _           | ng ph<br>as th   |               | IF FEMALE.   | - Herelo - zaki  |  |  |  |                                       |                              |                               |   |
| X<br>Q<br>Q | death certif<br>e attending<br>d for use as  | an/           | 23b. Was decedent pregnant   | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Fetal      |  | Ectopic pregnanc                         | "V                                       |                                       | 23d.                         | Date of deli                  | *   |
|             | e dea  | Sicie         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4 ☐ Pregnant at time of do                                     |  | Other (specify)                          |  |                                       |                              | Month                         | Day Year                                      |
| J.          | at the<br>i by the<br>stach  | Physician/Me  | 9 □ Unknown  |  |  |  |  |                                       |                              |                               |   |
| Ś           | law requires that the death certificate been signed by the attending is should be detached for use as  | by            | Part II. Other significant conditions con  | itributing to death but not resu                               | ilting in the ur   | nderlying cause giv                      | en in Part I.                            |                                       |                              |                               | the cause of death?                           |
| ecords,     | equir<br>sen s<br>ould   | be            |  |  |  |  |  | 1 ∐ Y                                 | es 2bogN                     | o 3∐ Pro                      | bbably 4 Unknown                              |
| ပ္ပ         | law r<br>as be<br>2 sh   | ompleted      |  |  |  |  |  | 24a. Was a                            |                              | 4b. Were aut                  | opsy findings available ompletion of cause of |
| ř           | : The law<br>cate has I<br>page 2 s  | Con           |  |  |  |  |  | perfor<br>1 □ Yes                     | med?                         | death?                        | 2 □No   |
| VITa        | ysician: The<br>iis certificate<br>director, pag   | Be (          | 25. Was case referred to medical examiner?   |  |  |  | 26. Place of De                          | ath (Check only or                    |                              |                               |   |
| 0           | S 0 =  | ြို           | 1⊠ Yes 2 □ No  | lospital: 1 ☐ Inpatient 2 ☐                                    | ER/Outpatier   | nt 3 DOA Oth                             | er: 4 🗆 Nursing I                        | Home 5 🔀 Resid                        | ence 6 🗆                     | Other (Spec                   | cify)   |
| 0           | ding Phy<br>h.<br>After thi<br>funeral o   |               | 27. Manner of Death 1 X Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day, Year)                      | 28b. Time of<br>Injury   | Wor                                      | ry at<br>k?                              | 28d. Describe h                       | ow injury oc                 | curred                        |   |
| UNISION     | Attending r death. ector: After by the fune  | ertification: | 2 ☐ Accident investigation   |  |  | M 1 □                                    | Yes 2 □ No                               |                                       |                              | _                             |   |
| Ĕ           | r Att<br>fer de<br>irecto  | ĬĬ            | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of Injury - At ho building, etc. (Specify           | me, farm, str  | eet, factory, office                     |  | 28f. Location (S<br>City or Tow       | treet and No<br>n, State)    | umber or Ru                   | ral Route Number,                             |
|             | ital c<br>irs af<br>ral Di   | O             |  |  |  |  |  |                                       |                              |                               |   |
|             | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | ical          | (Check only 2 Medical Examin   | sician: To the best of my knowner: On the basis of examination |  |  |  |                                       |                              |                               |   |
|             | the I<br>the I<br>the I  | Medical       | 29b. Signature and fittle of certifier   | and manner stated.   |  | 29c. Licens                              | se number                                |                                       | Od Date of                   | annd (Manth                   | Day Your                                      |
|             | 다.<br>한 1호 1호  | -             | 290. Signature and title of certifier  | , X  |  |  |  |                                       |                              | gned (Month                   |   |
|             |  |               | Jy Jum   |  |  | D205                                     | 35                                       |                                       | April                        | 9, 20                         | 08  |
|             | 20   |               | 30. Name and addless of person who of Roger Stevenson,   |  |  |  | #200                                     | Rethord                               | a Ma                         | rwl on 4                      | 20817   |
|             |  |               | 31 Date filed (Month Dev Voer)   |  |  | Treate Dr                                | , 1/200,                                 | Dernesa                               | a, Pid.                      | гутано                        | 2001/   |
|             | Sta  | te            | 31. Date filed (Month, Day, Year)  | 2. Registrar's Signat  | 1  | 56-                                      |  |                                       |                              |                               |   |

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ruth Downard McNeil 9, 2008 April 4:15AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Months Hours Min. 1 □ M 2 🔀 F 84 April 30, 1923 759-34-6938 Missouri Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Kensington 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4200 Dresden Street 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XI If Yes, Give Year or Dates: 2 X No 1 ☐ Yes 2X No Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Institutes of Health 1 Personnel Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Walter Downard Cecelia Goforth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Dresden Street, Kensington, Maryland 20895 Helen McNeil Whisman/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 15, 2008 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Dementia Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypotension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an Sepsis autopsy performed? 1 Yes 2 No

**Physician** /Medical **Examiner** Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ò 23a

items 2

0

"natural"

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nr any injury or other traumatic event, the Media once.

the Medical

must be notified

Director

Funeral

þ

Completed

Be ပ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician; 24 hours after death. After t

80/60/40

Division or Vital Records, P.O. Box 68760,

JENEIL, RUTH

Funeral Director: To the within 2 To the I 20 Physician/Medical 9 Unknown þ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No ပ 27. Manner of Death 1 X Natural Certification: 2 Accident

5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Tyes

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D53691

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) April 9, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Ajay Reddy, M.D. 6320 Democracy Boulevard, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature and title of

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month <sup>Day</sup> 2008 A M April 6, 5:15 Stanley J. McFarland, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Nursing Center Rockville 8. Date of Birth (Month, Day, Year March 15, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) Months Days Hours Virginia 1 X M 2 □ F 1929 79 215-22-8716 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Maryland| Potomac Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 United States 11718 Devilwood Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MX Yes 2 □ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Education College (1-4or 5+) Elementary/Secondary (0-12) Association Lobbyist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna L. Giegas Stanley J. McFarland, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11718 Devilwood Drive, Potomac, MD 20854 Nancy W. McFarland/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition April 10, 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Bethesda, MD 2008 4 ☐ Donation \_ 5 ☐ Other (Specify) M01346 Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Licenses R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Two Weeks Immediate Cause (Final Congestive Heart Failure Due to (or as a consequence of): Five Years Ischemic Heart Disease Due to (Gres a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

Department of Health ar Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

10a. State

Director

Funeral

2

Completed

Be

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death with in and Mental Hygiene.

is marked other than "natural", or items 23a or i

Pages 1 and 2 should

altimore, Maryland 21215-0036

Examine Physician/Medical

burial-tra physician as the attending properties for use as signed by the a certificate has t rector, page 2 s

the Hospital or Attending Physician: The law requires that the death certificate be executed this s after death.

I Director: After this of in by the funeral d

Division of Vital Records, P.O. Box 68760,

within 24 hours aft

To the Funeral Di

completely filled ir (5x1

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 🖂 Unknown Insulin Dependant Diabetes Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 ☐ Yes 2 No 1 □Yes Atrial Fibrillation 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

April 7, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 615 W. Montgomery Ave., Rockville, MD 20850 Christopher C. Dunford,

29c. License number

D31839

31. Date filed (Month, Day, Year) APR 1 1 2008

29b. Signature and title of certifier



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. DALTIMORE Dice 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Min. 1 □ M 2 1 F Months Days Hours 220-63-929 March 24, 1920 BALTIMORE ND Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must to redified at 1 ☐ Yes 2 No Director INI MMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ VOC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other traignts. A. JEORGI Zdni 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) APRIL BALTIMORE, lemote 21. Signature of Funeral Service/License BALTIMORE, MD2623 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each the. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔊 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BETTY NOTTINGHAM ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐Yes 2 X No 1 ☐ Yes 2 No ours after death. eral Director; After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

|            |  |                  | i icase i   | ypo or rimit in t                                      |   | Hellik. Elisare A   |   | c Legibic.   |   |  |  |
|------------|--|------------------|---|--|---|---|---|--|---|--|--|
|            |  |                  | 1 - For amend #22 Pe<br>Registrar   | State 6848 rylan                                       | d <b>/ 0s</b> p <b>ar</b> tme<br>Certifica              | ent of Health and late of Death                                   | Mental Hygie<br>Reg.                              | Z 1111()   | 11871   |  |  |
|            |  | 130              | 1. Decedent's Name (First, Middle, Last)  |  |   |   | 2. Date of Death                                  | D V  | 3. Time of Death                              |  |  |
|            | ° Physici  |                  | Mary E.D  | lotris   |   |   | 4 - 4 4   | Day Year   | 6:30AM  |  |  |
| ere.       | /Medic<br>Examir   | 194              | 4a. Facility Name (If not institution, give s   |  | 4b. C   | ity, Town, or Location of Deat                                    | 9 9   |  |   |  |  |
| 4          | Examil   | iei              | Ridgeway Manor  | · ·  | N.P.  | Catansville   |   | Balti  | more  |  |  |
|            | ***  |                  | 5. Social-Security Number 6. Sex  | 7. Age (In vrs.  | last birthday) If Un                                    | der 1 Year If Under 24 Hrs  | 8. Date of Birth                                  | 9. Birthr  | place (State or Foreign                       |  |  |
|            | Funeral Director   |                  | 230.40.7850 10  | M 2DE  | Yrs. Monti  | ns Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye               | oar) Coui  | ntry) W V                                     |  |  |
|            |  |                  | Usual Residence of Decedent   | 9  | •   |   | 11/10/11/1  |  |   |  |  |
|            | /lanc  |                  | 10a. State 10b. County  | 10c. Cit   | y, Town or Location                                     |   |   | 1  | 10d. Inside City Limits                       |  |  |
|            | Man,<br>-f sh  | ţō               | MD Baltim   | ove (  | )Wings 1  | Mills   |   |  | 1 Yes 2 No                                    |  |  |
|            | the 286  | rec              | 10e. Street and Number  |  |   | Zip Code  | 10g.  | Citizen of What Cour   | ntry?   |  |  |
|            | with SE or   | ۵                | 9515 Whitehur   | st Drive   |   | 21117   |   | USA  |   |  |  |
|            | ms 2   | Funeral Director |   | 2. Was Decedent Ever in U                              | .S. 13. Was De  | cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer          | Specify Yes or No-                                | 14. Race - Americ  |   |  |  |
| 10         | r Her  | Fun              | 1 ☐ Never Married 2 ☐ Married   | Armed Forces? 1 ☐ Yes 2 No If Yes, Give                |   |   | to Rican, etc.)                                   | Black, White,  | etc.  |  |  |
| 036        | urs a  | b                | 3 XWidowed 4 □ Divorced   | If Yes, Give<br>Year or Dates:                         | 1 ∐ Yes   | S 2 No Specify:   |   | Specify: 3   | ack   |  |  |
| 21215-0036 | n 72 hours after death with the Marylar<br>"natural", or flems 23s or 28e-f show<br>safted Exa. dihef : 48f be natified at   | ted              | 15. Decedent's Educ   |  | 16a. Decedent's U                                       | Isual Occupation work done during most of wo                      | 16t   | . Kind of Business/In  | dustry  |  |  |
| 21.5       | Pin 7  | ple              | (Specify only highest grade   | College (1-4or 5+)                                     | life. DO NO   | T use retired)  | ikiig   | Medic  | al  |  |  |
| 2          | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or flems 23s or 28e-f show event, the Medical Exc. direct cast by mailing at   | Completed        | 12th grade  | 4 years  | N   | Jurse   |   | 1 (60110   |   |  |  |
| b          | e file<br>al Hy<br>oth   | 3e (             | 17. Father's Name (First, Middle, Last)   |  |   |   | me (First, Middle, Mai                            | den Sumame)  |   |  |  |
| /a         | uld b<br>Ment<br>vrked<br>vrked  | To Be            | George Bayli  | S  |   | Bes   | SSIO FOX  |  |   |  |  |
| Maryland   | 2 should be filed within and Mental Hygiene. Is marked other than sumetic event, the Mental Hearthan and the Mental the M |                  | 19a. Informant's ame/Relationship (Ty)  | oe, Print)   | 19b. Mailing Addr                                       | ess (Street and Number or Ri                                      |   |  |   |  |  |
|            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importament of Heatth and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumetic event, the Macifal Examination and page.   |                  | George Inon   | 150/1, Dr.   |   |   | e Owing   |  |   |  |  |
| ore        | of He  |                  | 20a. Method of disposition 1   Burial 2 □ Cremation 3 □ R   |  | Place of Disposition (<br>emetery, crematory            | or other place)   |   | . Location - City or To  |   |  |  |
| Baltimore, | permit. Pages<br>Department of I<br>Important: If it<br>any injury or o<br>once.   |                  | `4 □ Donation 5 □ Other (Specify)   | D  | ruild Ridge   | e Cemetery 041  | 5/08 P  | ikesville) 1   | MD  |  |  |
| alt        | permit. Pag<br>Department<br>Important: I<br>any injury c  |                  | 21. Signature of Funeral Service License  | 8  | 22. Name  | and Address of Pacility V   | Mighn C. Grea                                     | enetuneral   | Services                                      |  |  |
| B          | 89 = 8   |                  | Vayagun C. &  | reene_   | 875   | 8728 Liberty 1  | 20ad Rand   | allstown M   | D 21133                                       |  |  |
|            |  |                  | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or  | cations that caused the deat                           | h. Do not enter the r                                   | node of dying, such as cardia                                     | c or respiratory arrest,                          |  | Approximate<br>Interval Between               |  |  |
|            | Pnysician<br>Pnysician   |                  | Immediate Cause (Final disease or condition   | A-Landonia   | auti Co   | roman Vercel  | an Du ane   | _  | Onset and Death                               |  |  |
|            | /Medical   |                  | resulting in death)   | Due to (or as a conseq                                 |   |   |   | = =  |   |  |  |
|            | Examiner   |                  | Sequentially list conditions  |  |   |   |   |  |   |  |  |
|            | D =  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseq                                 | uence of):  |   |   |  |   |  |  |
|            | cute   | Examiner         | Cause (Disease or injury that initiated events  |  |   |   |   |  | <u> </u>                                      |  |  |
| 0          | ite be executed ysician and  | EX               | resulting in death) Last  | Due to (or as a conseq                                 | uence of):  |   |   |  |   |  |  |
| 3760,      | eath certificate be executed attending physician and   | lical            |   |  |   |   |   |  |   |  |  |
| 99         | ing p  | Mec              | IF FEMALE:  |  |   |   |   |  |   |  |  |
| Вох        | th ce<br>tendi   | an/l             | 23b. Was decedent pregnant 2  | 3c. If yes, outcome of pregna<br>1☐Live birth 2☐Feta   |   | c pregnancy   |   | 23d. Date of delive<br>Month                                   | ery<br>Day Year                               |  |  |
|            | o dea  | sicl             | in the past 12 months?<br>1 □ Yes 2 ☑ No  | 4☐Pregnant at time of d<br>9☐ Unknown                  | eath 5 Other  | (specify)   |   | MONT   | Day   |  |  |
| P.0        | at the   | Physiclan/Med    | 9 Unknown   |  |   |   | an Didukt   |  |   |  |  |
|            | The law requires that the death certifica<br>ate has been signed by the attending ph<br>page 2 should be defached for use as t   | by               | Part II. Other significant conditions con   | tributing to death but not res                         | ulting in the underlyir                                 | ig cause given in Part I.   |   | co use contribute to t   |   |  |  |
| Records,   | w requir<br>been si<br>should  | ted              | Personeel Visco   |  |   |   | 1 🗆 Yes   | 2 NO 3 FIO   | Dably 4 Marikilowii                           |  |  |
| ec         | as b   | e di             | Periphered Visco  | Our Blees  |   |   | 24a. Was an autopsy                               | prior to co  | ppsy findings available impletion of cause of |  |  |
| - H        |  | Completed        |   |  |   |   | performed<br>1 ☐ Yes 2 ☑                          |  | 2 🕒 No  |  |  |
| Vital      | Physicien: The law<br>this certificate has braid inector, page 2 s   | Be (             | 25. Was case referred to medical examiner?  |  |   |   | ath (Check only one)                              |  |   |  |  |
| of V       | Physic<br>this or  | ၉                | 1 ☐ Yes 2 ☑ No  |  | ER/Outpatient 3   |   | Home 5 Residenc                                   | e 6 ⊡Other (Specia   | fy)   |  |  |
| n c        | ding Phy<br>h.<br>After thi<br>funeral   | ü.               | 27. Manner of Death  1 ☐ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)               | 28b. Time of<br>Injury                                  | 28c. Injury at<br>Work?   | 28d. Describe how                                 | injury occurred  |   |  |  |
| 0          | endi<br>eath.<br>or: A<br>he fu  | atle             | 2 Accident investigation  |  | М   | 1 ☐ Yes 2 ☐ No  |   |  |   |  |  |
| Division   | I or Attendi<br>after death.<br>Director: A<br>I in by the fu  | Certification;   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h<br>building, etc. (Special | ome, farm, street, fac<br>(y)                           | tory, office  | 28f. Location (Stree<br>City or Town, S           | it and Number or Run<br>State)                                 | al Route Number,                              |  |  |
|            | itel c   |                  |   |  |   |   | 1   |  |   |  |  |
|            | Hospitel   | edical           | (Check only 2 Medical Examir  | ier: On the basis of examina                           | owledge, death occur<br>itio <i>n</i> and/or investigat | red at the time, date and place<br>tion, in my opinion, death occ | e, and due to the caus<br>urred at the time, date | e(s) and man <i>n</i> er as s<br>and place, a <i>n</i> d due t | stated.<br>o the cause(s)                     |  |  |
|            | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.  | Med              | one)  29b. Signature and title of certifier   | and manner stated.                                     |   | 29c. License number   | 29d.  | Date signed (Month,  | Day, Year)                                    |  |  |
|            | ₹ <u>₹</u> ₹ 8   |                  | . 0 .   | 200000000000000000000000000000000000000                | ,   | T-101-0-  |   | 4-09- 200  | 18  |  |  |
|            | ,/   |                  | Threesel &  |  | - 00-) (7 5 : : :                                       | 1307061   | 0   | 10100  | 7   |  |  |
|            | 5  |                  | 30. Name and address of person who co   | impleted cause of death (Iter                          | 1 23a) (Type, Print)                                    | D19667  e Highway *   | COS Gles  | Busuer, or   | 61  |  |  |
|            | Sta  | te               | 31. Date filed (Month, Day, Yaar)   | 3. Registrar's Signa                                   | ture /  | 4   |   |  |   |  |  |
|            | Registi  |                  | APR 1 1 2008  | Colors L   | T AGENTA  | ,   |   |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elaine F. Oltman 4-9-2008 4:55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 109 Ravenswood Ct. Joppa Harford Co. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 □ M 2 T F 60 Yrs Director 216-50-1329 Md Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Eventing it set by putilised at Director 1 ☐ Yes 2√☐ No Md. Harford Joppa 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? death with 109 Ravenswood Ct. 21085 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other the any injury or other trainments. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 👿 Married 1 ☐ Yes 2 🙀 No Specify. ğ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst UN.Med.Med. Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William J. Rubenstein Florence MacKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Oltman Husband 109 Ravenswood Ct. Joppa, Md.21085 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, cremato 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-12-2008 Balto. Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASTOT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) ed by the detached i 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy perform 2 🗖 No 1 □Yes To the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 9c. License Humbs. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. K. Ley G. BM (670) N. Charles St. batts Md Zc 2d x

31. Date filed (Month St.)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

10

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** APRIL **EDWARD** OFFIT 2008 **JOSEPH** 8 10:10A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RUXTON OF PIKESVILLE HEALTH CTR. BALTIMORE PIKESVILLE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) Sex 1M 2□F 7. Age (In yrs. last birthday) **Funeral** 212-09-0620 102 01/11/1906 MD Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MD PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 SUDBROOK ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) PROPRIETOR TAVERN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental BENJAMIN OFFIT ဥ SARAH UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau BARBARA LICHTENBERG / DAUGHTER 2418 FOREST GREEN ROAD, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/2008 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cruse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) whenosclevorio **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 Probably 4 □Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3008 6565 N. Charles St Suite 209 State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001 OCME 2006

Registra

Melissa Brassell, MD

31. Date filed (Mond, Day, Year)

111 Penn Street, Baltimore, MD 21201

cal Examiner

Assistant Med

|  |                  | Pleas  | e Type or Print i                                     |                      |  |  | _                                  |                   | •   |  |
|--|------------------|--|---|----------------------|--|--|------------------------------------|-------------------|---|--|
|  |                  | For<br>State<br>Registrar  | State of Mary   | /land /              | Department of F<br>Certificate of                |  | d Mental Hy                        | _                 |   |  |
|  | ь.               | Registrar     Decedent's Name (First, Middle,                                      | (ast)   |                      | Certificate of                                   | Dealli                                       | 2. Date of De                      | Reg. No.          | 2008  | 3. Time of Death                                 |
| Physicia   |                  | ANINIE S   |   | EAK                  | LE.  |  | Month O4                           | Day               | Year 2008   | 10.50 AM   |
| /Medic<br>Examin   |                  | 4a. Facility Name (If not institution,   |   | - // -               | 4b. City, Town, o                                | r Location of De                             |                                    | 4c.               | County of Death                                     | 103011   |
|  |                  | 6404 Wood Poin   | te Drive  |                      | GENT   | ALE  |                                    | T.                | rince   | GEORGES  |
| Funeral  |                  | Social Security Number     6   | . Sex 7. Age (In                                      | n <i>yrs. last</i> i | Months Days                                      | If Under 24 H<br>Hours Mi                    |                                    | rth<br>ay, Year)  | 9. Birthr   | place (State or Foreign                          |
| Director   |                  | 577-66-3141  | 1UM 2MF 58  |                      | Yrs.   |  | 02/                                | 12/19             | 150 South   | Carolina   |
| M +I   |                  | Usual Residence of Decedent  10a. State 10b. County                                | 10  | c. City, To          | own or Location                                  |  |                                    | •                 | 1   | Od. Inside City Limits                           |
| ⊢f sh<br>fied a  | tor              | MD Prin  | CF DEBrass 1  | GLI                  | ENDALE   |  |                                    |                   |   | 1K∐Yes 2□No                                      |
| Department of Health and Mental Hygiene.<br>Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show<br>any injury or other traumatic event, the Medical Examiner must be notified at<br>once.             | Funeral Director | 10e. Street and Number   | /   |                      | 10f. Zip Code                                    |  |                                    | 10g. Citi         | zen of What Coul                                    | ntry?  |
| 23a c  | al D             | 6404 W   | od Perinte  | Dri                  | ive 207  | 69   |                                    | -                 | 1)5A  |  |
| er mi  | une              | 11. Marital Status   | 12. Was Decedent Ever<br>Armed Forces?                | r in U.S.            | 13. Was Decedent of H<br>If Yes, specity Cub     | lisp <i>a</i> nic Origin?<br>an, Mexican, Pu | (Specity Yes or Nerto Rican, etc.) | 0-                | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |  |
| or if  | by Fi            | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced                               | 1 ☐ Yes 2 X No<br>If Yes, Give<br>Year or Dates:      |                      | 1 ☐ Yes 2 🔀 No                                   | Specify:                                     |                                    |                   | Specify:  | lack   |
| tural<br>al Ex   | ted b            | 15. Decedent's   |   | 16                   | <br>6a. Decedent's Usual Occur                   | pation                                       |                                    | 16b. Ki           | nd of Business/In                                   |  |
| n "na<br>Medic   | plet             | (Specify only highest<br>Elementary/Secondary (0-12)                               |   | - 2                  | (Give kind of work done life. DO NOT use retired | during most of v<br>d)                       | vorking                            |                   |   | ,  |
| giene<br>rr tha  | Completed        | Elementary/Secondary (0-12)  | 2 yrs.  | ]                    | Program Analy                                    | st   |                                    | U.                | S. Gov  | ernment  |
| al Hy  | Be               | 17. Father's Name (First, Middle, La   | est)  |                      |  | 18. Mother's N                               | lame (First, Middle                | e, Maiden         | Surname)  |  |
| Ment<br>arkec<br>atic e  | 힏                | Preston Marti  |   |                      |  |  | ret catti                          |                   |   |  |
| ls m<br>raum   |                  | 19a. Informant's Name/Relationship   | (Type. Print)   |                      | 9b. Mailing Address (Street                      |  |                                    | _                 |   | Code)  |
| Healt<br>em 27<br>ther 1   |                  | Ned Peake 20a. Method of Disposition   | 12  |                      | 404 Wood Poil                                    | nte Dr.                                      | Glendale                           |                   | cation - City or To                                 | own State  |
| nt of  |                  | 1 <b>X</b> Burial 2 ☐ Cremation 3  | ☐Removal from State                                   | ceme                 | etery, crematory or other pla                    | i  |                                    |                   | -   |  |
| artme<br>ortani<br>injun   |                  | 4 □ Donation 5 □ Other (Spe<br>21, Signature of Funeral Service Lie                |   | Mt.                  | Olivet 22. Name and Addre                        |  | 18-2008<br>Marchall'               |                   | hington,  |  |
| Depar<br>Impo<br>any ir<br>once  |                  | Chiles Dim   | and 00  |                      | 4217 9th   |  |                                    |                   |   |  |
| 700  |                  | 23a. P. nt1 Enter the disease, or co<br>shick, or heart failure. List or           | emplications that caused the                          | death. D             |  |  |                                    |                   |   | Approximate<br>Interval Between                  |
| ysician  |                  | Immediate Cause (Final disease or condition  |   |                      | oscle not  | in Con                                       | nalaou A                           | false             | Meense  | Onset and Death                                  |
| Medical  |                  | resulting in death)  | Due to (or as a co                                    | onsequence           | ce of):  | C CEPPE                                      | orney 4                            | TRIT              | LICETISE  |  |
| aminer   | Examiner         | Sequentially list conditions.  | b   |                      |  |  |                                    |                   |   |  |
| ##   |                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a co                                    | onsequenc            | ce of):  |  |                                    |                   |   |  |
| and<br>Il-tran   | хап              | Cause (Disease or injury that initiated events resulting in death) Last            | c<br>Due to (or as a co                               | onseauend            | ce of):  |  |                                    |                   |   |  |
| sician   | -                |  | V.  | ,                    |  |  |                                    |                   |   |  |
| g phys   | edic             |  | d   |                      |  |  |                                    |                   |   |  |
| anding<br>use a  | M/m              | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome pf p                             |                      |  |  |                                    |                   | 23d. Date of deliv                                  | ery  |
| e atte   | sicia            | in the past 12 months?<br>1 ☐ Yes 2 No   | 1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim             |                      |  | у  |                                    |                   | Month   | Day Year   |
| by th  | Physician/Medica | 9 ∐ Unknown `  | 9□Unknown   |                      |  |  |                                    |                   |   |  |
| been signed by the attending physician and should be detached for use as the burial-transit  | by               | Part II. Other significant condition   |   | ot resulting         | g in the underlying cause giv                    | en in Part I.                                |                                    |                   |   | he cause of death?                               |
| een s  | Completed        | 1) DIABET  |   |                      |  | _  |                                    |                   | XNo 3 ☐ Prol  | bably 4 □Unknown<br>—                            |
| has b<br>e 2 st  | nple             | 2) END STA   | AGE MENAL   |                      | USEASE   |  | 24a. Was                           | psy               | prior to co   | opsy findings available<br>empletion of cause of |
| icate<br>r, pag  |                  |  |   |                      |  |  | Yes                                | formed?<br>2 □ No | death?<br>1 XI Yes                                  | 2□No   |
| certif   | Be               | 25. Was case referred to medical examiner?   | Hospital:   |                      | Outpotiont 3 DOA Oth                             |  | Death (Check only                  |                   |   |  |
| r this   | To               | 1 ☐Wes 2 No  27. Manner of Death   | 28a. Date of Injury                                   | 281                  | b. Time of Injury 28c. Inju                      | 4 LI Nursing                                 | g Home 5 Res                       |                   |   | fy)  |
| within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Certification:   | 1 Natural 5 Pending 2 Accident investiga   | (Month, Day Ye  | ear)                 |  | rk?<br>∣Yes 2 □ No                           |                                    | •                 | ,   |  |
| ector<br>by the  | ifica            | 3 Suicide 6 Could no determin  |   | - At home,           | , farm, street, factory, office                  |  |                                    |                   |   | al Route Number,                                 |
| al Dir<br>ed in  | Cert             | Tionnoide  | building, etc. (c                                     | эреспу)              |  |  | - City of 10                       | own, State        | ,   |  |
| wimin 24 mous aret obeam.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.   |                  | (Check only 2 Medical E  | Physician: To the best of maniner: On the basis of ex |                      |  |  |                                    |                   |   |  |
| the F  | Medical          | one)   | and manner stated                                     | l.                   |  |  |                                    |                   |   |  |
| 200  | 2                | 29b. Signature and title of certifier  | 6) X  | 1 .                  | MD 29c. Licens                                   | e number                                     |                                    | 29d. Da           | te signed (Month,                                   | uay, Year)                                       |
| 1  |                  | MES  | IC KE   | 1                    | /'/\mathcal{D} \ P223                            | 72   |                                    | APA               | U-5-2   | 008  |
| り  |                  | 30. Name and address of person w   | no completed cause of death                           | h (Item 23:          | a) (Type, Print) Matth                           | ew KAra                                      | fin                                | 1.71              | 0 MA  | 021287   |
| Sta  | te               | 31. Date filed (Month, Day, Year)  | Registrar's   | Signature            | a) (Type, Print) Matth                           | WOHR   | DI DA                              | LIN               | 10; 210   | 100  |
| Registr  |                  | NDD 1 1 7  | 008   | S                    | STATE !  |  |                                    |                   |   |  |
| H 17 Rev 1/20  | 001              | HIU TT P   |   |                      | -  |  |                                    |                   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 943 PM averr 2008 April 00 /Medical 4a. Facility Name (If not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner ohns HODKINS baymen center If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday, 5. Social Security Number Funeral Days Hours 1**X** M 2□ F Months 06-02-1933 Nebraska 540-34-5302 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Martha Ct Unit 101 21015 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M genee. 12 +Computer Programmer APG 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hans Petersen Ellen Craft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1603 Martha Ct Bel Air, MD 21015 Dolores B. Petersen (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-10-2008 | Fallston, Maryland Highview Mem. Gar. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Linesee Inc. 610 W. MacPhail Rd BEl Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dalis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 □ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2□No 1 ☐ Yes ours after death.

eral Director: After this certificatile in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue 4940 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Powell 1730 M 2003 Trone /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Future Care Nursing Baltimore Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months **X** M 2□ F 214-56-5786 57 Director 50 01 NY Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f shov sdical Examiner must be notified at 1√Yes 2□No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 3901 Baveva Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: Completed by Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse na Warehouse Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Hattie Haley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trainonce. 3901 Baveva Road, Baltimore, Md 21215 Michelle Ockimey-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc 4/14/08 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 3a. P /1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s rock, or heart failure. List only one cause on each line. immediate Cause (Final Hheoselestic 1eavs **Physician** Cenebral disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, todaing to main solution cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Inknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, P.0. Division or Vital Records, Hospital or Attending Physiclan:

ours after death.
neral Director: A
filled in by the fu 24 hours a Funeral I within 24 hou

To the Fune

completely fi

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

29b. Signature and title of certifier

Medical

30. Name and address of person who completed caus 2,6011

of death (Item 23a) (Type, Print) Many

and manner stated.

Reistantam

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

037573

8' SOOS

29d. Date signed (Month, Day, Year)

MD 51136

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24ate of Manyland 18 enarrance of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 4 R. Palmer Willis 12:54 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MARYLAND 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** sex 1☑M 2□F Days Hours 216-32-0380 みし Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits MD 1 XYes 2 No Director 10e. Street and Number og. Citizen of What Country? Funeral U5A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Completed by 3 Widowed 4 Divorced -ACK other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) US POSTAL ARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( ONA ျှ WILLIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIVIAN C. PALMER 503 TIMORE, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 X Burial 2 ☐ Cremation 3 Removal from State 04-10-08 OWINGS MILLS, MB 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FULTON AVEL JR, FUNERALHOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Gastro-Intestinal hemorrhand 1mmediate /Medical Due to (or as a consequence of) **Examiner** ulcer disease UNKAOWA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐Yes 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946-1124 ss of person who completed cause of death (Item 23a) (Type, Print) Borack

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day,

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32. Registrar's Signature

Hospital

08-02691 Kennedi Roscoe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| delinedi Noscoe  |               | State of Mar<br>1- For State<br>Registrar   | yiand / Departi<br><i>Certif</i>       | ment of Heal<br>icate of Deat |  |                                  | , No. 200                        | 8 1187  |
|--|---------------|---|--|-------------------------------|--|----------------------------------|----------------------------------|---|
| Physici  | an/           | Decedent's Name (First, Middle,Last)  |  |                               |  | 2. Date of Death                 | Day Year                         | 3. Time of Death                                    |
| Medical Exami  | ner           | Kennedi Nijaa  4a. Facility Name (if not institution, give street and                           | Olivia                                 |                               | scoe   | April 5, 200                     | 8                                | 1715 hrs  |
| ment .   |               | University Hospital   | number)                                | Baltin                        | own, or Location of Dea<br>nore                    | atn                              | 4c. County of Death              | 1   |
| Funeral  |               | 5. Social Security Number 6. Sex  | 7. Age (In yrs. last                   |                               |  |                                  | (MM/DD/YYYY) 9. Bir<br>Foreig    |   |
| Director   |               | 218-79-5786 1 M 2X  | F                                      | Yrs. 0.6                      | s Days Hours M                                     | in. 10/1/                        | Co                               | ountry) MD  |
| any  |               | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, To                          | wn or Location                |  |                                  |                                  | 10d. Inside City Limits                             |
| <u>*</u> ,   | _             | MD NA   | Ba                                     | ltimore                       |  |                                  |                                  | 1 X Yes 2 No  |
| daryland<br>28a-f show<br>1 at once.   | Director      | 10e. Street and Number  |  | 10f. Zip                      | Code   | 10                               | g. Citizen of What Cou           | ntry?   |
| h the N<br>3a or   | ٥             | 11 Torlina Ct. Apt  | A                                      |                               | 21207  |                                  | U.S.A                            | A •   |
| 0036 within 72 hours after death with the Maryland jeine. ner than "matural", or items 23a or 28a-f sho Medical Examiner must be notified at once.   | Funeral       |   | Decedent Ever in U.S. d Forces?        |                               | nt of Hispanic Origin? (<br>y Cuban, Mexican, Puer |                                  | 14. Race - Amer<br>White, etc.   | ican Indian, Black,                                 |
| ler dez<br>", or i   |               | 3 Widowed 4 Divorced If Yes, Give   |  | 1 Yes 2                       | X No specify:                                      |                                  | Specify:                         | Black   |
| 5-0036<br>led within 72 hours after<br>thygiene.<br>other than "natural",<br>the Medical Examiner  | d by          | 15. Decedent's Education (Specify only highest  | grade completed) 16                    | a. Decedent's Usual           | Occupation (Give kind o                            |                                  | 16b. Kind of Business/           |   |
| 36<br>n 72 h<br>nan "n<br>ical E   | Completed     |   | e (1-4 or 5+)                          |                               | king life. DO NOT use r                            | etirea)                          | 27 / 2                           |   |
| -003<br>d withi<br>giene.<br>ther the  | E O           | N/A NA  17. Father's Name (First, Middle, Last)   |  | N/A                           | 18 Mother's Nar                                    | ne (First, Middle, M             | N/A                              | -   |
| 21215-0036 July be filed within 7 Mental Hygiene, i marked other than ic event, the Medica   | Be            | Corey Roscoe  |  |                               | Ciara  |                                  | ardon barriamo,                  |   |
| ID 21<br>should and Mer<br>7 is man  | ٩             | 19a. Informant's Name/Relationship (Type, Print )   | 17.                                    |                               | (Street and Number of                              |                                  |                                  |   |
| ≥ 5 th m m d ≤   |               | Ciara Jones-Mother  20a. Method of Disposition  |  | 11 Torli                      | na Ct, Ap  | ot A, Ba                         | 1timore, 20c. Location - City or |   |
| altimore,<br>mit. Pages I a<br>portante of He<br>portant: If ite   |               |   | al from State crer                     | natory or other place         |  |                                  | ·                                |   |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oth  |               | 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee                            | Kin                                    | 22. Name and                  | al Park 4  |                                  | Randalls                         | stown, Md   |
| Den Den Inju   |               | Flyn Dokok  | 2                                      | March                         | F/H West<br>Wabash Av                              | :<br>e, Balt                     | imore, Mo                        | 21215   |
| Physician<br>/Medical  |               | 23a. Part I. Enter the disease, or complications the failure. List only one cause on each line. | at caused the death. Do                |                               |  |                                  |                                  | Approximate Interval<br>Between Onset and           |
| Examiner   |               |   | with Complication                      | ons                           |  |                                  |                                  | Death   |
| ,  |               | Sequentially list conditions, b.  | is a consequence of):                  |                               |  |                                  |                                  |   |
|  | iner          | if any, leading to immediate Due to (or a   | as a consequence of):                  |                               |  |                                  |                                  |   |
| / p  | Examiner      | (Disease or injury that initiated events resulting in death) Last C. Due to (or a               | as a consequence of):                  |                               |  |                                  |                                  |   |
| executed<br>an and<br>al - transi  |               | d.  UNPENDED X AMENDE   | - A G                                  | 070 / 1                       | T 00 .   |                                  |                                  |   |
| 760, ficate be executed g physician and the burial - transit   | Medical       |   | 9 per fh                               |                               | 0-08 VE  |                                  | 23d. Date of deliver             |   |
| 687<br>ertifica<br>ding p  |               | 23b. Was decedent pregnant in the past 12 months?   | ve birth                               | 2 Fetal death                 | 3 Ectopic preg                                     | nancy                            |                                  | Day Year  |
| Box 687  e death certific  the attending p   | Physician/    | 4 Vee 2 of No C Ustrama   | egnant at time of death                | 5 Other (Spe                  | cify)  |                                  |                                  |   |
| P.O. Box 687<br>s that the death certific<br>gned by the attending<br>e detached for use as t  |               | Part II. Other significant conditions contributir   | g to death but not resul               | Iting in the underlying       | cause given in Part I.                             | 23e. Did tob                     | pacco use contribute to          | the cause of death?                                 |
| S, P.C   | ed by         |   |  |                               |  | 1 Yes                            | 2 ✔ No 3 Pro                     |   |
| ords,<br>aw requii<br>as been a<br>2 should  | plet          |   |  |                               |  | 24a. Was a autops                | y prior to                       | utopsy findings available<br>completion of cause of |
| Rec<br>The la  | Completed     |   |  |                               |  | perform<br>1 <b>Y</b> Yes 2      | ned? death?  No 1 ✓ Y            | es 2 No   |
| Division of Vital Records, pital or Attending Physician: The law requirours after death. eral Director: After this certificate has been sifilled in by the funeral director, page 2 should   | å             | 25. Was case referred to medical examiner?  | Inpatient 2 ER                         | ,                             | 26.Place of Death (Chec                            |                                  | Residence 6 Othe                 |   |
| of V<br>g Phys<br>fter thi   | 밁             | 27. Manner of Death 28a. D  | ate of Injury 28                       |                               | 28c. Injury at Work?                               |                                  | Residence 6 Other                | ····  |
| ion (tending eath.   | tiol          | Telluling   Manual  |  | OUND:<br>330 hrs              | 1 Yes 2 V No                                       | Subject foun                     | d with plastic bag               | covering face                                       |
| ivisi<br>or At<br>after d<br>Direct  | Certification | 3 Suicide 6 Could not be 28e. F   | lace of Injury - At home               |                               | , office building, etc.                            | 28f. Location (Si<br>or Town, St |                                  | ural Route Number, City                             |
| D<br>ospital<br>hours<br>ineral  |               | 29a Certifier   | fy) Multi-Family                       |                               |  | 11 Torlina Cou                   | rt Apt. A, Gwynn Oa              |   |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the | edical        | (Check only one) 2 Medical Examiner: On the ba  | sis of examination and/o               |                               |  |                                  |                                  |   |
| To Vii   | Me            | 29b. Signature and title of certifier   | er stated.                             | 290                           | . License number                                   |                                  | 29d. Date signed (Mo             | onth, Day, Year)                                    |
|  |               | Malin Brassel .   | ne)                                    |                               | O.C.M.E.   |                                  | April 6, 2008                    |   |
|  |               | 30. Name and address of person who completed of   | •                                      | ,                             | not Dolling  | D 24224                          |                                  |   |
|  | ate           |   | Medical Examiner Registrar's Signature | TIT Penn St                   | reet, Baltimore, M.                                | U 21201                          |                                  |   |
| Regist   |               | APR 1 1 2008  | Prome K                                | South                         |  |                                  |                                  |   |
| DHMH 17 Rev 1/20   | ΙUI           | /   |  | ORIGINAL                      |  |                                  |                                  |   |

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death

2. Date of Death

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|---|-----|-----|-----|----|
|   | 1   | 3.6 | 3.4 |    |
|   | - 1 | 1.1 | U.  | -1 |

3. Time of Death

| Physician |
|-----------|
| /Medical  |
| Examiner  |
| Examiner  |

1. Decedent's Name (First, Middle, Last)

the death certificate be executed attending physician and for use as the burial-tran ed by the a detached f signed by

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

The Day APRIL 8. 2008 5:55F Charlotte Cecelia Ridenour 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 🛛 F 215-22-3903 80 Director 11-03-1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director **Baltimore** Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Goucher Blvd. 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own\_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matilda F. Walecki Thomas Stroble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Peeples/Daughter 2600 Gunpowder Farms Rd., Fallston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-12-2008 Parkville, MD 4□Donation 5 Q Other (Specify) Mausoleum Parkwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ANOXIC ENCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CARDIO RESPIRATORY ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine MYOCARDIAL INFARCTION Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOGENIC SHOCK 1 Xes 2 No 3 Probably 4 Unknown Completed PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 RICHARD LINTHICUM M. D 7601 OSLER DRIVE TOWSON. MARYLAND 21204 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 1 1 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year -sther obinsor 1400 2008 ADEL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Year If Under 24 Hrs. Mion 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 219-1291-27A 1 ☐ M 2 🕱 F -10-1924 Balto MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3113 Windsor U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 12 yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jenkins illie Watt Mac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 E. 36th -harles Balto JenKins 21218 St mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 9/2008 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery Juynn Oak, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HACKETT FUNCTURE CHAPEL 3:4-Upshir Street N w 21. Signature of Funeral Service Licenses Nackett W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Drain EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 □ Yes 2 □ No 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-trar

Examine

Be Completed by

Certification: To

Medical

and attending physician for use as the buria ed by the a signed by page 2 should certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director,

Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O.

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowf

6 Could not be

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

28a. Date of Injury (Month, Day Year)

and manner stated.

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

10581 FM

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

BAtimore Md 21218

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

CHRISTOPHER D. KENNOV Union Memorial

State Registrar 31. Date filed (Month, Day, Year) 11 APR

| 4a. Facility Name (if not institution, give street and number) 409 East Ridgeville Boulevard  4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4de. C | 3. Time of Death 1600 hrs  ath  Birthplace (State or Foreign Country)  MD |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician/ 1 Decedent's Name (First, Middle,Last)  Dennis Patrick Renehan  4a. Facility Name (if not institution, give street and number) 409 East Ridgeville Boulevard  409 East Ridgeville Boulevard  5. Social Security Number 217-50-2017  1 X M 2 F 57  Yrs.  2. Date of Death Month April 8, 2008  4b. City, Town, or Location of Death Mt. Airy  Carroll  4c. County of Death Mt. Airy  Carroll  Months Days Hours Min.  Mar 17, 1951   | ath  Birthplace (State or Foreign Country)  MD                            |  |  |  |  |  |  |  |
| Dennis Patrick Renehan  4a. Facility Name (if not institution, give street and number) 409 East Ridgeville Boulevard  4b. City, Town, or Location of Death 409 East Ridgeville Boulevard  4b. City, Town, or Location of Death 4c. County of Death 4d. Carroll  Funeral Director  5. Social Security Number 217-50-2017  1 X M 2 F 57  Yrs.  4b. City, Town, or Location of Death 4d. County of De | ath  Birthplace (State or Foreign Country)  MD                            |  |  |  |  |  |  |  |
| 409 East Ridgeville Boulevard  Mt. Airy  Carroll  Funeral Director  5. Social Security Number 217-50-2017  1 M 2 F 57  Yrs. Months Days Hours Min. Mar 17, 1951  | Birthplace (State or Foreign<br>Country)<br>MD                            |  |  |  |  |  |  |  |
| Funeral Director 5. Social Security Number 217-50-2017 6. Sex 1. Age (In yrs. last birthday) 5. Social Security Number 217-50-2017 7. Age (In yrs. last birthday) 5. Social Security Number 217-50-2017 8. Date of Birth (MM/DD/YYYY) 9. Example 1. Age (In yrs. last birthday) 1. Months Days Hours Min. Mar 17, 1951   | Country) MD   |  |  |  |  |  |  |  |
| Director 217-50-2017   1 Mm 2 F 57 Yrs.   Months Days Hours Min.   Mar 17, 1951  | Country) MD   |  |  |  |  |  |  |  |
|  |   |  |  |  |  |  |  |  |
| Usual Residence of Decedent  |   |  |  |  |  |  |  |  |
| 10a. State 10b. County 10c. City, Town or Location Union Bridge  | 10d. Inside City Limits 1 Yes 2 X No                                      |  |  |  |  |  |  |  |
| MD Carroll Union Bridge  10e. Street and Number  10g. Citizen of What Co   | - 11  |  |  |  |  |  |  |  |
| (10307 Copper Mine Court 21791 USA   | ,   |  |  |  |  |  |  |  |
| The Carroll Union Bridge  10e. Street and Number  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  10g. Citizen of What Co  11g. Was Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  11g. Was Decedent Ever in U.S.  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  11g. Was Decedent Ever in U.S.  11g | erican Indian, Black,   |  |  |  |  |  |  |  |
| 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:  White, etc.   |   |  |  |  |  |  |  |  |
| Specify: \[ \frac{1}{2} \]  \[ \ | White<br>ss/Industry  |  |  |  |  |  |  |  |
| 98 O   |   |  |  |  |  |  |  |  |
| S = 12 Contractor Constru  | uction  |  |  |  |  |  |  |  |
| Constructor  Constructor  Constructor  17. Father's Name (First, Middle, Last)  Sidney Renehan  Sidney Renehan  Mary Elizabeth Barcus  19a. Informant's Name/Relationship (Type, Print)  |   |  |  |  |  |  |  |  |
| To plant the state of the state |   |  |  |  |  |  |  |  |
| Mrs. Terry Renehan (Spouse) 10307 Copper Mine Ct., Union Bridge. No 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City  | 4D 21791  |  |  |  |  |  |  |  |
| Proposed in the state of the st |   |  |  |  |  |  |  |  |
|  | te, MD  |  |  |  |  |  |  |  |
| 1 3 Sykesville, MD 21/84   |   |  |  |  |  |  |  |  |
| Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   | Approximate Interval<br>Between Onset and                                 |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):   | Death   |  |  |  |  |  |  |  |
| Sequentially list conditions, b  |   |  |  |  |  |  |  |  |
| if any, leading to immediate Due to (or as a consequence of):  |   |  |  |  |  |  |  |  |
| cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |   |  |  |  |  |  |  |  |
| 32 27 MF 979 / /1c/09 1  |   |  |  |  |  |  |  |  |
| 99 pg fig. and pg  | verv  |  |  |  |  |  |  |  |
| AMENDED 23a, 27 per ME g878 4/16/08 amh    X UNPENDED   AMENDED 23a, 27 per ME g878 4/16/08 amh   X UNPENDED   AMENDED 23a, 27 per ME g878 4/16/08 amh   X UNPENDED   AMENDED 23a, 27 per ME g878 4/16/08 amh   X UNPENDED   AMENDED 23a, 27 per ME g878 4/16/08 amh   X UNPENDED   AMENDED 23a, 27 per ME g878 4/16/08 amh   IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1 Live birth 2 Fetal death 3 Ectopic pregnancy   Month     Yes 2 No 9 Unknown   9 Unknown   9 Unknown   9 Unknown   9 Unknown   9 Unknown   1 | Day Year  |  |  |  |  |  |  |  |
| Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown  |   |  |  |  |  |  |  |  |
| AMENDED   23d, 27 per ME 8878 4/10/08 amin   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12 months?   23d. Date of delivery personal properties of the past 12   |   |  |  |  |  |  |  |  |
| Part II. Uther significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute   1   Yes 2   No 3   Proposed to the part of | autopsy findings available  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓   | o completion of cause of  |  |  |  |  |  |  |  |
| Performed ocean  1 ✓ Yes 2 No 1 ✓  25. Was case referred to medical examiner?  | Yes 2 No  |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)  26. Place of Death (Check only one)  26. Place of Death (Check only one)  4   | her: Scene  |  |  |  |  |  |  |  |
| C se la la la la la la la la la la la la la  |   |  |  |  |  |  |  |  |
| Value 1  |   |  |  |  |  |  |  |  |
| Continuo de la control de la c | Rural Route Number, City  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st  |   |  |  |  |  |  |  |  |
|  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c. License number  29d. Date signed (A. April 9, 2008)  | Month, Day,Year)  |  |  |  |  |  |  |  |
| 30. Telline and address of person who completed cause of death (Item 23a)  |   |  |  |  |  |  |  |  |
| Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |   |  |  |  |  |  |  |  |
| State 31. Date filed (Month, Day, Year) 2008 Registrar APR 1 1 2008  |   |  |  |  |  |  |  |  |

Registrar DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** EITHA 1958 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAROMA PAR MONTEOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 577-50-1575 Director 03-01-1937 DC Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 1814 41st Place, by Funeral 20020 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government years Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ?7 is marked c Samuel Saunders 2 Annie Burth of Health and M Item 27 is man r other trauman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susie Hedgepeth/ Sister 5106 South Dakota Ave, NE Washington, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4-15-2008 Suitland, Maryland Lincoln Memorial 22. Name and Address of Facility Marshall's Funeral Home of Funeral Service Licensee 21. Signatu 4217 9th Street, NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dusito (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗚 No Month Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ Slo 24a. Was an certificate has birector, page 2 s autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ←B/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 □ Pending investigation 1 TYes 2 TNo 2 ☐ Accident within 24 hours after death To the Funeral Director; filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confiser 29c. License number 29d. Date signed (Month, Day, Year)

To the I

State 31. Date filed

DARCIE
31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sporter

04,05,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #26 Per Phy 8878 4/11@ Stiff at e of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0432AM Jerome J. Siatkowski 4 3 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 120sedale Baltimore FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 01-25-1947 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **™** M 2□ F 218-46-7943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Winslow Dr 21015 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 +Constable State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casimir Siatkowski Amelia Kryglik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole McBride (Daughter) 4315 Perkins Place Belcamp, MD 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakgrove Church Cem. 04-07-2008 Bel Air, Maryland 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air
MD 21014 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiac Due to (or as a consequence of): arrhyThmia Sequentially list conditions

**Physician** /Medical Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipluy or other traumatic event once.

erci

Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral I Registrar

| Ical Examine | if any cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  C  |   |
|--------------|--|--|---|
| 1ysician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)   | 23d. Date of delivery<br>Month Day Year   |
| ed by Pr     | Part II. Other significant conditions  | contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ √No 3 ☐ Probably 4 ☐ Unknown     |
| Comple       |  |  | 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Mo   |
| D<br>D       | 25. Was case referred to medical examiner?   | 26. Place of Death (C  | Check only one)   |
| 0            | 1 ☐ Yes 2 ☐ No   | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ Other: 4 ☐ Nursing Home  | 5 ☐ Residence 6 ☐ Other (Specify)   |
| allon:       | 27. Manner of Death  1   | 28b. Time of linjury (Month, Day Year)  n  | d. Describe how injury occurred   |
| פנווויי      | 3 Suicide 6 Could not be determined  |  | . Location (Street and Number or Rural Route Number,<br>City or Town, State)                        |
| earcar       | 29a. Certifier (Check only one)  1 Certifying P: 2 Medical Exa   | hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | d due to the cause(s) and manner as stated.<br>at the time, date and place, and due to the cause(s) |
|              | 29b. Signature and title of certifier  | 29c. License number 0005 470 2   | 29d. Date signed (Month, Day, Year) 4 - 3 - 2008  |

State

DRNona

31. Date filed (Month, Day, Year)

P. Novello MD

APR 1 1 2008

9000

32 Registrar's Signature

FRANKLIN SQUARE DR

md 2123

Balto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 13:35 M **Physician** Rose Agnes Staab 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto. Union Memorial Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, Year) f Under 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🗓 F 87 Yrs 10-1-1920 Md. Director 141-01-8651 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Balto. Md. Balto. Co. Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21239 USA 1651 East Belvedere Avenue Apt. 205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: White 1 Never Married 2 Married 1□Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 10th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Machovec Albert Pete ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Madera, Ca. 93637 3316 Camino Ct. Sharon Caruana 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2008 4 Donation 5 Other (Specify) DulanevVallev Timonium 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ce Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Complication Immediate Cause (Final Cardiac Valve Responent 1 month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumon ia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? jo 4□Pregnant at time of death 5 Other (specify) been signed by the s 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Q page perform 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year) APR 11

29b. Signature and title of certifier

Preston



P. Jones

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sores

1312 Guilford Ave Apt #332, Bultimore MD

M.D.

at - 2438946 - HZ8

State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04-10-2008 730 A Naomi Louise Schneehagen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 300 Sunflower Drive Apt 239 Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 😾 F Vrs 217-07-6241 04-30-1920 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hyglene. Importent: If Item 27 is marked other then "neturel", or Iteme 23s or 28e-1 ehow any njury or other treumatic event, the Mudical Exaction must be notified at once. 1 ☐ Yes 2√ No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 U.S.A. 300 Sunflower Drive Apt 239 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White þ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Naomi Worth Joseph Sieber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 904 Dellwood Drive Fallston, MD 21047 Bonnie Hoffman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-14-2008 Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** near resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural efter death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 056545 4/11/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL TIR MD HAYS ST # 102 KHOSLA 206 31. Date filed (Month, Day, Year) 32. Régistrar's Signature APR 11 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 16:21 M ROLD SENTT APRIL 80 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HSPITAL DAL RITA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Days 67 Yrs. 218-38-2752 March 12, 1941 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Parkville MD. Baltimore 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2518 Wycliffe Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 63-6 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No 63-64 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Post Office Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Senft Elanore Recnike 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3341 Willoughby Rd. Parkville, MD. 21234 Mary J. Francis/ Daughter 20b. Place of Disposition (Name of Dulanetery crematory of other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/12/08 Timonium, MD. Memorial Gardéns 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee/ Evans funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD. 21234 3a. Paul! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician MOCARDIAL /Medical resulting in death) Due to (or as a consequence of): **Examiner** ORONARY Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine THEKOSCLE attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ANCER 24a. Was an page 2 s autopsy 21 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury Natural 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Atter ding Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Variet inspectors after death.

To the Funeral Director After this certificate to completely filled in by the funeral director, pag

altimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MO

La certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

21239

BLUD BALTIMORE

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

560 LOCH

32. Penistrar's Signature Sept s

|                         |  |                   | Please   | Type or Prin                                    |                             |                              |   |                                    |  |                         | .egible.  |   |           |
|-------------------------|--|-------------------|--|---|-----------------------------|------------------------------|---|------------------------------------|--|-------------------------|---|---|-----------|
|                         |  |                   | For<br>State<br>Registrar  | State of Ma                                     | aryland                     |                              | rtment of H<br>tificate of L              |                                    | з мептат ну                              | giene<br>Reg. No.       | 2008  |   | 888       |
|                         | 16.3   |                   | 1. Decedent's Name (First, Middle, Las   |   |                             |                              |   |                                    | 2. Date of De                            |                         | Year  | 3. Time of                                |           |
| e i                     | Physicia<br>/Medic   |                   |  | AYNE  | STE                         | RNER                         |   |                                    | 4  | 3                       | 2008  |   | 13PM      |
|                         | Examin   | er                | 4a. Facility Name (If not institution, give  |   | 62 C.                       | enTen                        | 4b. City, Town, or                        | Location of De                     |  |                         | County of Deat                                  |   |           |
|                         | Funeral  |                   | 5. Social Security Number 6. Se  | ex 7. Age                                       | e (In yrs. la               | st birthday)                 | If Under 1 Year<br>Months Days            | If Under 24 h                      |  | rth<br>ay, Year)        | 9. Birt<br>Co                                   | hplace (State o                           | r Foreign |
| J.                      | Director   |                   | 214-50-2823 Usual Residence of Decedent  | <b>2</b> M 2□F                                  | 60                          | ) Yrs.                       |   |                                    | 6-22-                                    | 1948                    | PE  | NNSYLV                                    | ANIA      |
|                         | ryland<br>thow   | _                 | 10a. State 10b. County   | IMORE   | 10c. City,                  | Town or Loc                  |   | OSEDAI                             | Æ  |                         |   | 10d. Inside Cit                           |           |
|                         | the Ma<br>28a-f s<br>otified   | ecto              | 10e. Street and Number   |   |                             |                              | 10f. Zip Code                             |                                    |  | 10a, Citiz              | en of What Co                                   |   |           |
|                         | should be filed within 72 hours after death with the Maryland<br>nd Mental Hygiene.<br>marked other than "natural", or items 23a or 28a-f show<br>imatic event, the Medical Examiner must be notified at | Funeral Director  | 1601 SUMMIT AV   | /ENUE   |                             |                              |   | 237                                |  |                         | U.S.  | -   |           |
|                         | tems ter mu  | uner              | 11. Marital Status   | 12. Was Decedent I<br>Armed Forces?             |                             | . 13. V                      | Vas Decedent of Hi<br>f Yes, specify Cuba | ispanic Origin?<br>ın, Mexican, Pı | (Specify Yes or No<br>Lerto Rican, etc.) | 0- 1                    | <ol> <li>Race - Ame<br/>Black, White</li> </ol> |   |           |
| 36                      | urs afte   | þ                 | 1 Never Married  Married 3 Widowed 4 Divorced                                      | 1  Yes 2  | ™<br>1967-                  | -70 <sup>1</sup>             | □Yes 2√2 No                               | Specify:                           |  |                         | Specify: WH                                     | ITE                                       |           |
| 2-0036                  | 72 hou   | Completed         | 15. Decedent's Ed<br>(Specify only highest gra                                     | ucation<br>de completed)                        |                             | (Give                        | lent's Usual Occup-<br>kind of work done  | during most of                     | working                                  | 16b. Kin                | d of Business/                                  | Industry                                  |           |
| 121                     | within<br>iene.<br>than '  | dmo               | Elementary/Secondary (0-12)  | College (1-4or 5                                | i+)                         | me. L                        | NOT use retired WELDER                    | ,                                  |  | TAT                     | E ENG   | INEERI                                    | NG        |
| nd 2                    | al Hygi<br>I other<br>vent, t  | Be C              | 17. Father's Name (First, Middle, Last)  | CMEDNE  | D 01                        | `                            |   |                                    | Name (First, Middle                      | , Maiden S              | Surname)  |   |           |
| Maryland                | should be<br>and Mental<br>marked o  | ို                | LEIGHTON P.  19a. Informant's Name/Retationship (7)                                | STERNE  | κ, δι                       | -                            | g Address (Street                         | RUTH                               | E.                                       | (RAA                    |   | Zin Code)                                 |           |
|                         | a is a   |                   | ANTOINETTA STE   |   | E                           |                              | SUMMIT                                    |                                    | ROSEDA                                   | -                       |   | 1237                                      |           |
| altimore,               | 0 0  |                   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐                            | Removal from State                              | 20b. Pla                    | ace of Dispo<br>metery, cren | sition (Name of<br>natory or other place  | ce)                                | Date                                     | 20c. Loc                | cation - City or                                | Town, State                               |           |
| Ē                       | Pa<br>int:   |                   | 4 □ Donation 5 □ Other (Specify  | )   | GAI                         |                              | OF FAI                                    |                                    | -12-08                                   |                         | TIMOR   |   | HOME      |
| Ba                      | permit. Departr Importa any inju   |                   | 21. Signature of Funeral Service Licen   | 3   | X                           |                              | 211 CHE                                   |                                    |  |                         | LE, M   |   |           |
|                         |  |                   | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only     | olications that caused<br>one cause on each lii | the death.                  | Do not ent                   | er the mode of dyin                       | ig, such as car                    | diac or respiratory                      | arrest,                 |   | Approximat<br>Interval Bet<br>Onset and I | ween      |
|                         | Physician //   |                   | Immediate Cause (Final disease or condition resulting in death)                    |   | STag                        | -                            | C, O, P. D                                |                                    |  |                         |   | Onoct and I                               |           |
|                         | Examiner   |                   |  | Due to (or as                                   | a conse Tu                  | ence ot):                    |   |                                    |  |                         |   |   |           |
| 7                       | p tis  | xaminer           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as                                   | a consequ                   | ence of):                    |   |                                    |  |                         |   |   |           |
| V                       | executed<br>and<br>al-transit  |                   | Cause (Disease or injury that initiated events resulting in death) Last            | cDue to (or as                                  | a consequ                   | ence of):                    |   |                                    |  |                         |   |   |           |
| 68760                   | that the death certificate be e<br>ed by the attending physician<br>detached for use as the burie  | ical E            | (  | .d  |                             |                              |   |                                    |  |                         |   |   |           |
| 39 ×                    | certifica<br>ding ph   | /Med              | IF FEMALE:   | 23c. If yes, outcome                            | of pregnar                  | ncv                          |   |                                    |  | 2                       | 3d. Date of de                                  | liven                                     |           |
| B                       | death death death death death  | ician             | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No             | 1 □Live birth<br>4 □ Pregnant a                 | 2 Fetal                     | death 3                      | Ectopic pregnancy Other (specify)         | /                                  |  |                         | Month   |   | Year      |
| Vital Records, P.O. Box | The law requires that the death certificate be to has been signed by the attending physicia bage 2 should be detached for use as the bur   | Physician/Medical | 9 Unknown  | 9□Unknown                                       |                             | ting in the u                | adorthing gauge give                      | on in Bort I                       | 22e Did                                  | tobaccour               | ee contribute t                                 | o the cause of c                          | teath?    |
| ds,                     | signed d   | ρ                 | Part II. Other significant conditions of   | ontributing to death b                          | ut not resu                 | ung in the u                 | ndenying cause giv                        | en in Fait i.                      |  | _                       |   | robably 4 🗆 l                             |           |
| COL                     | aw requir<br>s been si<br>s should   | Completed         | -  |   |                             |                              |   |                                    | 24a. Wa                                  |                         | 24b. Were a                                     | utopsy findings<br>completion of c        | available |
| E E                     |  | Som               |  |   |                             |                              |   |                                    | per                                      | opsy<br>formed?<br>2 No | death?  |   | ause or   |
| Vita                    | ician:<br>certific<br>rector,  | Be                | 25. Was case referred to medical examiner?   | Hospital:                                       |                             | - D/O 1 1 1                  | ot 3 DOA Oth                              | or.                                | Death (Check only                        |                         |   |   |           |
| Division or             | g Phys<br>er this<br>eral di   | n: To             | 1 ☐ Yes 2 ☐ No  27. Manner of Death  | 28a. Date of Inju                               | ıry                         | 28b. Time o                  | II 3 DOX                                  | 4 LI Nursii                        | ng Home 5 ☐ Res<br>28d. Describe         |                         |   | ecity)                                    |           |
| Sior                    | Attending<br>r death.<br>ector: After<br>by the fune   | Certification:    | 1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be         |   |                             |                              | M 1                                       | Yes 2 □ No                         | 001                                      | (0)                     |   | 15. ( )                                   |           |
| <u>S</u>                | i or At<br>after d<br>Direct<br>i in by  | ertifi            | 4 Homicide determined  | Zoe. Flace of III]                              | ury - At noi<br>c. (Specify | ne, tarm, str<br>)           | eet, factory, office                      |                                    | City or T                                | own, State)             | a Number or H<br>)                              | ural Route Nun                            | iber,     |
| _                       | To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral  |                   | (Check only 2 Medical Exar   | ysician: To the best<br>niner: On the basis o   |                             |                              |   |                                    |  |                         |   |   | s)        |
|                         | o the F<br>ithin 24<br>o the F<br>omplete  | Medical           | one)  29b. Signature and title of ertification                                     | and manner st                                   | ated.                       |                              | 29c. Licens                               | se <b>n</b> umber                  |  | 29d. Date               | e signed (Mon                                   | th, Day, Year)                            |           |
|                         | F ≯ F 8  |                   | ) (ell)  |   |                             |                              | RES                                       | 0000                               |  | 4/0                     | 08/200  | 28  |           |
| ,                       | 19   |                   | 30. Name and address of person who   |   |                             |                              |   |                                    |  | T                       |   |   |           |
|                         | Sta  | te.               | OR CEDRIC M. F. 31. Date filed (Month, Day, Year)                                  | 32. Registr                                     | ar's Signat                 | ure                          | Lin Sau                                   | are l                              | ) R Bal                                  | 10.1                    | nd Z  | 1237                                      |           |
|                         | Regist   |                   | APR 11   | 2008  | eline.                      | H                            | doub!                                     |                                    |  |                         |   |   |           |
| DH                      | IMH 17 Rev 1/2   | 001               |  |   |                             |                              | GINAL                                     |                                    |  |                         |   |   |           |
|                         |  |                   |  |   |                             |                              |   |                                    |  |                         |   |   |           |

|                            |   | 1                | For State Registrar   | State of M  | aryland               | / Depa                      | artment o                                | of Health ar<br>of Death                     | nd Ment                        |                                      | iene<br>eg. No.        | 2008                              | 11890  |
|----------------------------|---|------------------|---|---|-----------------------|-----------------------------|--|--|--------------------------------|--------------------------------------|------------------------|-----------------------------------|--|
|                            |   |                  | Decedent's Name (First, Middle, La  | ast)  |                       |                             |  |  |                                | ate of Deat                          | th<br>Day              | Year                              | 3. Time of Death                                   |
|                            | Physicia  |                  | Doris E. Strit  |   |                       |                             |  |  | Api                            |                                      | 4                      | 2008                              | 6:00 P M   |
| 1000                       | /Medic  |                  | 4a. Facility Name (If not institution, gi   |   | )                     |                             | 4b. City, To                             | wn, or Location of                           | Death                          |                                      | 4c. C                  | County of Death                   |  |
| )                          | Examin  | er               | Montgomery Hos  |   |                       | e                           |  | ville  |                                |                                      |                        | ntgomer                           |  |
|                            | Funeral<br>Director   | - 1              | Social Socurity Number 6  |   | ge (In yrs. la:<br>87 |                             |  | Year If Under 24<br>Days Hours               |                                | ate of Birth<br>Month, Day,<br>rch 1 |                        | Coul                              | place (State or Foreign<br>ntry)<br>achusetts      |
| as the                     | opiologija - Stilling ( n.  | _ <u> </u>       | Usual Residence of Decedent   |   | Tion City             | Town or Lo                  | reation                                  |  |                                |                                      |                        |                                   | 10d. Inside City Limits                            |
|                            | nylan<br>how<br>at  | .                | 10a. State 10b. County  |   |                       |                             |  |  |                                |                                      |                        |                                   | 1 ☐ Yes 2 No                                       |
|                            | e Ma<br>3a-f s<br>tiffec  | cto              | Maryland Frederi  | -ck   | Fre                   | deric                       | 10f. Zip C                               | 'ode   |                                |                                      | 10g. Citiz             | en of What Cou                    | ntry?  |
|                            | e no  | Dir.             | 10e. Street and Number  | D 1   |                       |                             |  | 704  |                                |                                      |                        | ed Stat                           |  |
|                            | ath w   | ra               | 9005 Bealls Farm  | 12. Was Deceder   | t Ever in II S        | 13.                         |  | nt of Hispanic Orig<br>y Cuban, Mexican,     | in? (Specify                   | Yes or No-                           |                        | 4. Race - Amer                    | can Indian,  |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural" or 20 may injury or other traumatic event, the Medical Examiner must be notified at once. | 큔                | 11. Marital Status  1 ☐ Never Married 2 ☐ Mamed 3 ☒ Widowed 4 ☐ Divorced  | Armed Forces  1  Yes 2   If Yes, Give  Year or Dates      | No<br>No              | - 1                         |  | y Cuban', Mexican,<br>∑ No Specify:          | , Puerto Rica                  | n, etc.)                             |                        | Black, White Specify: Wh          |  |
| 8                          | hour<br>Itural  | - Pa             | 15 Decedent's   | Education   |                       | 16a. Dece                   | edent's Usual                            | Occupation                                   | of working                     |                                      |                        | nd of Business/I                  |  |
| 5                          | in 72<br>n "na<br>n Medic   | plet             | (Specify only highest g   | rade completed) College (1-40                             | r 5+)                 | life.                       | DO NOT use                               | done during most retired)                    | or working                     |                                      | _                      | artment                           | of the   |
| 12                         | with<br>jene.<br>r thar   | Completed by     | Elementary/Secondary (0-12)   | 2   |                       | Secr                        | etary                                    | <del></del>                                  |                                |                                      | Navy                   |                                   |  |
| b                          | Hyg<br>other<br>ent,  | O e              | 17. Father's Name (First, Middle, La  | st)   |                       |                             |  |  | r's Name <i>(Fil</i>           |                                      |                        | Surname)                          |  |
| Maryland 21215-0036        | ald be<br>fenta<br>rked<br>ric ev   | To Be            | Walter L. Kimber  |   |                       |                             |  |  | J. Loc                         |                                      |                        | - T Ctoto 7                       | in Code)   |
| ary                        | shou<br>and N<br>man  |                  | 19a. Informant's Name/Relationship  | (Type. Print)   |                       |                             |  | Street and Numbe                             |                                |                                      |                        |                                   |  |
| Ž                          | alth a  |                  | Patricia C. Ross  | /Daughter   |                       |                             |  | ls Farm R                                    |                                |                                      | rick,                  | cation - City or                  | 7U4<br>Town State                                  |
| ē,                         | of Hei  |                  | 20a. Method of Disposition<br>1 → Burial 2 ☐ Cremation 3  | □Removal from Sta   | te Ch                 | ace of Disp<br>emetery, cre | osition (Nam<br>ematory or ot<br>nam Vet | e of<br>her place)<br>eran's                 | prilDate                       | 0,                                   |                        | ltenham                           |  |
| E                          | Page<br>nent on<br>int: If  |                  | 4 □ Donation 5 □ Other (Spe   | cify)   | one.                  | Cen                         | netery                                   |  | 2008                           | CT A                                 |                        |                                   |  |
| Baltimore,                 | permit. Departn Imports any inju  |                  | 21. Signature of Funeral Service Lie  | 111   | M013                  | F                           | Rockvil                                  | lle, Mary                                    | land 4                         | 20850                                |                        | gomery A                          | ineral Home/<br>Avenue                             |
|                            |   |                  | 23a. Part1. Enter the disease, or conshock, or heart failure. List or   | inplications that causely one cause on each               | sed the death         | . Do not e                  | nter the mode                            | e of dying, such as                          | cardiac or re                  | spiratory a                          | rrest,                 |                                   | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician   |                  | Immediate Cause (Final disease or condition   | Pneumo  |                       |                             |  |  |                                |                                      |                        |                                   |  |
| )                          | /Medical  | Н                | resulting in death)   |   | as a consequ          | uence of):                  |  |  |                                |                                      |                        |                                   |  |
|                            | Examiner  |                  | a statute de la conditiona  | b. Dement   |                       |                             |  |  |                                |                                      |                        |                                   |  |
|                            |   | Je.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or  | as a consequ          | uence of):                  |  |  |                                |                                      |                        |                                   |  |
| St.                        | e be executed<br>/sician and<br>e burial-transit  | Examiner         | Cause (Disease or injury that initiated events  | c   |                       |                             |  |  |                                |                                      |                        |                                   |  |
| M                          | te be execu<br>ysician and<br>ie burial-tra   | EX               | resulting in death) Last  | Due to (or  | as a consequ          | uence ot):                  |  |  |                                |                                      |                        |                                   |  |
| ,094                       | 0 2 0   | ical             | ,   | d   |                       |                             |  |  |                                |                                      |                        |                                   |  |
| 89                         | rtifica<br>ng ph<br>as tl   | Med              | IF FEMALE:  |   |                       |                             |  |  |                                |                                      |                        | 23d. Date of de                   | livery   |
| Box 68                     | iclan: The law requires that the death certificate certificate has been signed by the attending physector, page 2 should be detached for use as the   | by Physician/Med | 23h Was decedent pregnant   | 23c. If yes, outco  | h 2 ☐ Feta            | death 3                     | 3 ☐ Ectopic pr                           |  |                                |                                      |                        | Month                             | Day Year   |
|                            | e dea   | sici             | in the past 12 months? 1 ☐ Yes 2 ☒ No   | 4∐Pregnar<br>9□Unknow                                     | nt at time of d<br>n  | leath :                     | 5 ☐ Other (sp                            | ecity)                                       |                                |                                      |                        |                                   |  |
| P.O.                       | at the<br>by the  | Phy              | 9 ☐ Unknown  Part II. Other significant condition   | se contributing to dea                                    | th but not res        | ulting in the               | underlying c                             | ause given in Part                           | I.                             | 23e. Did                             | tobacco                | use contribute t                  | o the cause of death?                              |
| Ś                          | es the  | b                | Part II. Other significant condition  | 15 CONTRIBUTING TO LIVE                                   |                       | · ·                         |  |  |                                | 1 🗆                                  | Yes 2                  | 2 □ No 3 □ P                      | robably 4 Vunknown                                 |
| ord                        | requir  | Completed        |   |   |                       |                             |  |  |                                | 24a. Was                             | s an                   | 24b. Were a                       | utopsy findings available                          |
| ec                         | law las be  | ple              |   |   |                       |                             |  |  |                                | auto                                 | opsy<br>formed?        | prior to                          | completion of cause of                             |
| 8                          | The<br>ate h  | Son              |   |   |                       |                             |  |  |                                |                                      |                        | o 1 □ Ye                          | s 2 No   |
| /ita                       | clan:<br>ertific  | Be               | 25. Was case referred to medical examiner?  | Hospital:   |                       |                             |  | Other  | ce of Death (                  |                                      |                        | eX Other (Sn                      | ecify) Hospice                                     |
| 7                          | Physic<br>this c  | P                | 1 ☐ Yes 2 📉 No  | 28a. Date of  |                       | 28b. Time                   | tient 3 □ D0                             | 28c. Injury at<br>Work?                      |                                |                                      |                        | ury occurred                      | edity Hospice                                      |
| ū                          | ding Physician: ). After this certific funeral director,  | on:              | 27. Manner of Death 1 X Natural 5 □ Pending   | (Month  | , Day Year)           | Injur                       | ry<br>M                                  | Work?<br>1 ☐ Yes 2 ☐                         | ]No                            |                                      |                        |                                   |  |
| Sio                        | eath.<br>tor: /   | cati             | 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n   | ot be 280 Place C   | of injury - At h      | ome, farm,                  | street, factor                           | y, office                                    | 28                             | f. Location                          | (Street a              | and Number or F                   | Rural Route Number,                                |
| Division or Vital Records, | or At<br>after d<br>Direct<br>in by   | Certification:   | 4 Homicide determi  | ned buildin   | g, etc. (Spec         | ify)                        |  |  |                                | City or 1                            | own, Stai              | ie)                               |  |
|                            | To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the  |                  |   | g Physician: To the ba<br>Examiner: On the ba<br>and mann | sis of examin         | owledge, d<br>ation and/o   | eath occurred<br>or investigation        | d at the time, date a<br>n, in my opinion, d | and place, ar<br>eath occurred | nd due to th<br>d at the time        | ne cause(<br>e, date a | (s) and manner<br>nd place, and d | as stated.<br>ue to the cause(s)                   |
|                            | the thin 2 the mplet  | Medical          | 29b. Signature and title of certifie  | andmann   |                       |                             | 29                                       | c. License number                            | r                              |                                      | 29d. D                 | ate signed (Mo                    | nth, Day, Year)                                    |
|                            | 7 × 5   |                  | Allnere   | M. (1)  | ~ .c                  |                             |  | D0064615                                     |                                |                                      | Apr                    | il 4, 2                           | 800  |
|                            |   |                  | 30. Name and address of person  | who completed enise                                       | of death (Ite         | m 23a) (Tv                  |  |  |                                |                                      |                        |                                   |  |
|                            | 14  |                  |   |   | 105                   | 5 Pic                       | card D                                   | rive, Ro                                     | ckvill                         | e, MD                                | 208                    | 350                               |  |
|                            |   | State            | Genevieve Wrob  31. Date filed (Month, Day, Year)   | ewski M.  | egistrar's Sign       | nature                      | 1 4                                      |  |                                |                                      |                        |                                   |  |
|                            |   | State<br>Strar   |   |   |                       | K A                         | 2300                                     |  |                                |                                      |                        |                                   |  |

|  |                 | •              | For<br>State<br>Registrar  | State of Maryl  |   | rtment of H<br>tificate of L                             |   | -  | giene<br>Reg. No.                                      | 20   | 08                              | Proceedings &                 | 891                   |  |
|--|-----------------|----------------|--|---|---|--|---|--|--|--|---------------------------------|-------------------------------|-----------------------|--|
| Phy  | sicia           | n              | 1. Decedent's Name (First, Middle, Las   | t)  |   |  |   | 2. Date of De<br>Month   | eath<br>Day  | /  | Year                            | 3. Time o                     |                       |  |
|  | ledic           |                | Harriet Stev   |   |   |  | 6, 20   |  |  | 4:15   | A M                             |                               |                       |  |
| Exa  | amin            | er             | 4a. Facility Name (If not institution, give  |   |   | Rockvi   | Location of Death                                     |  | 4c.  | County o   |                                 |                               |                       |  |
| Fune   | aral            |                | Rockville Nursing 5. Social Security Number 6. S   |   | If Under 1 Year   | If Under 24 Hrs.   | 8. Date of Bir  | Montgomery  Birth Day, Year)  9. Birthplace (State or Fo. Country) |  |  | or Foreign                      |                               |                       |  |
| Direc  |                 |                | 192-10-0055  | □M 2 <b>X</b> IF  | 93 Yrs.   | Months Days  | Days Hours Min. (Month, D<br>February                 |  |  |  |                                 |                               |                       |  |
| yland  | ii ii           |                | Usual Residence of Decedent  10a. State 10b. County  | 10c   | . City, Town or Lo  | cation   |   |  |  |  | 10                              | 0d. Inside C                  | City Limits           |  |
| Mar.   | Tiled           | ctor           | Maryland Montgo  | merv  | Rockvill  | Le   |   |  |  |  |                                 | 1 ☐ Yes                       | 2 <b>∑</b> No         |  |
| th the   | 000             | Director       | 10e. Street and Number   |   |   | 10f. Zip Code  |   |  | 10g. Citi  | izen of W  | hat Coun                        | try?                          |                       |  |
| ath wi   | 9               | ra             | 4621 Cherry Valle  | y Drive   |   | 20853  |   |  |  | ited   | Stat                            | es                            |                       |  |
| partition (e), Interpretation 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "patural", or items 23a or 28a-f show   | Xaringru        | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever if Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | - 1   | Vas Decedent of Hi<br>fYes, specify Cuba<br>I □Yes 2XINo | ispanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No<br>Rican, etc.)                                   | )-   |  | , White, e                      |                               |                       |  |
| 72 hou   | dical           | Completed      | 15. Decedent's Ed<br>(Specify only highest gra   | (Give   | lent's Usual Occupa   | ing  | 16b. Ki   | ind of Bus   | iness/Inc  | Justry   |                                 |                               |                       |  |
| within ene.  | 0 N             | dmc            | Elementary/Secondary (0-12)  College (1-4or 5+)  2  Secretary  |   |   |  |   |  |  | Re   | tail                            | L                             |                       |  |
| filled<br>Hyg  | ent, I          | Be C           | 17. Father's Name (First, Middle, Last)  |   |   |  | 18. Mother's Name                                     | e (First, Middle   | , Maiden   |  |                                 |                               |                       |  |
| Jid be<br>Mental   | ic ev           | 은              | Harry Lee  |   |   |  | Clara S   | Schade   |  |  |                                 |                               |                       |  |
| ary<br>shot<br>and h   | anma            |                | 19a. Informant's Name/Relationship (7  | Type. Print)  | 19b. Mailin   | g Address (Street a                                      | and Number or Rur                                     | al Route Number, City or Town, State, Zip Code)                    |  |  |                                 |                               |                       |  |
| and 2<br>and 2<br>ealth<br>n 27 i  | er fr           |                | Lee Arthur / Daug  | <u></u>   |   | Cherry Va  |   |  |  |  |                                 |                               | 20853                 |  |
| ges 1<br>Fiter F   | or of           |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐  | Removal from State  | b. Place of Dispos<br>cemetery, cren  | sition (Name of<br>natory or other plac                  | e) April  | Date 10.   | 20c. Lo  | ocation - C  | City or To                      | wn, State                     |                       |  |
| t. Pages<br>rtment of<br>rtant: If it  | nlu l           |                | 4 □ Donation 5 □ Other (Specify  | ) H:  | ighwood   | Cemetery   | 1   | 2008   |  |  |                                 | nsylvar                       |                       |  |
| permi<br>Depa<br>Impo  | any II          |                | 21. Signature of Funeral Service Picen   | MO  | $\frac{1473}{86}$   | Name and Address the sda-Cathesda,                       | hevy Chas<br>Marvland                                 | se, Inc<br>20814-  | ., 7 <u>5</u><br>3501                                  | 557 W  | rur<br>Jisco                    | nsin                          | Ave.                  |  |
|  |                 |                | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee   |   |   |  |   |  |  |  |                                 |                               | tween                 |  |
| Physici<br>/Medic  | _               |                | disease or condition resulting in death)  Hypertensive Heart Disease   |   |   |  |   |  |  |  |                                 |                               |                       |  |
| Examir   | _               |                | Due to (or as a consequence of):  Pneumonia  |   |   |  |   |  |  |  |                                 |                               |                       |  |
|  |                 | Ē              | Sequentially list conditions,  | b. Due to for as a con  |   |  |   |  |  |  |                                 |                               |                       |  |
| bouted of  | ausii           | Examiner       | Sequentially list conditions, if any, beauty to manufact cause. Enter Underlying Cause (Disease or injury that initiated events  | . Demen   | ntia  |  |   |  |  |  |                                 |                               |                       |  |
| te be execusion ar   | nual-ri         | ш              | resulting in death) Last   | Due to (or as a con   | sequence of):   |  |   |  |  |  |                                 |                               |                       |  |
| tificate be executed g physician and   | ille n          | edical         |  | d   |   |  |   |  |  |  |                                 |                               |                       |  |
| ath cer  | ched for use as | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown  |   |   |  |   |  | 23d. Date of delivery<br>Month Day Year                |  |                                 |                               |                       |  |
| that the de  |                 |                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23e. Did tobacco use contribute to the cause of death? |  |                                 |                               |                       |  |
| w requires to been signer to should be a   |                 | ed by          | Deep Vein Thrombosis   |   |   |  |   |  | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown                |  |                                 |                               | Unknown               |  |
| The law reate has be   | V               | Completed      |  |   |   |  |   |  |  | pr<br>de   | ere autorior to coreath?        | psy findings<br>mpletion of a | available<br>cause of |  |
| clan:<br>ertific   | , cio,          | Be             | 25. Was case referred to medical examiner?   |   |   |  | 26. Place of Deat                                     |  |  |  |                                 |                               |                       |  |
| hysic<br>this c  | an dire         | ၉              | 1 ☐ Yes 2 🙀 No   | Hospital:<br>1 ☐ Inpatient<br>28a. Date of Injury                                 |   |  |   |  |  |  | ☐ Residence 6 ☐ Other (Specify) |                               |                       |  |
| nding Physician: The lith.  th. After this certificate his patients of the pat |                 | ation:         | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28b. Time of Injury   | 28b. Time of   28c. Injury at   28c/2 |  |   | 28d. Describe how injury occurred                                  |  |  |                                 |                               |                       |  |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director; A   | in by iii       | Certification: | 3 Suicide 6 Could not be determined  | At home, farm, streecify)   |   |  |   |  |  | on (Street and Number or Rural Route Number,<br>r Town, State) |                                 |                               |                       |  |
| ne Hospi<br>n 24 hou<br>ne Funer   | pietery III     | Medical        | 29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |  |  |  |                                 | (s)                           |                       |  |
| To the To | ro t            | Ž              | 29b. Signature and title of certifier  29c. Licenson  D00  |   |   |  |   | 29d. Date signed (Month, Day, Year)                                |  |  |                                 |                               |                       |  |
|  |                 |                | Noma   | D00   | 47330   | 30 April 7, 2008   |   |  |  |  |                                 |                               |                       |  |
| 1  | 7               |                | 30. Name and address of person who   |   |   |  |   |  | , .  | 000  |                                 |                               |                       |  |
|  | State           |                | Thomas Joseph, M.I<br>31. Date filed (Month, Day, Year)  | ). 50 West 1<br>2. Registrar's S  | Edmonston   | n Drive,   | Kockville   | e, Mary  | Land   | 2085   | 2                               |                               |                       |  |
| * Reg  | Stat<br>gistra  | ·              | APR 1 1 200  | ر معنوس   | ignature  |  |   |  |  |  |                                 |                               |                       |  |

State of Maryland / Department of Health and Mental Hygiene 2000

|  | _   | State<br>Registrar  |  |  |                                   | Ce                             | rtificate (   | of Death  |  |   | g. No.   | 100                      | 1109   |
|--|---|---|--|--|-----------------------------------|--------------------------------|---|---|--|---|--|--------------------------|--|
| Physicia   | _   | 1. Decedent's Name (F  Rebecca H  |  |  | 1                                 |                                |   |   |  | Date of Deatl<br>Month<br><b>April</b>  | Day  | Year                     | 3. Time of Death 12:05 PM                            |
| /Medica<br>Examine   | 10  | Rebecca Hershey Thomason  4a. Facility Name (If not institution, give street and number)  Renaissance Gardens   |  |  |                                   |                                | 4b. City, Town, or Location of Death  Silver Spring |   |  |   | 11 5, 2008 12:05 4c. County of Death  Montgomery |                          |  |
| Funeral<br>Director  |   | 5. Social Security Number 579-22-31   | 78   | Sex<br>1□M 2⊠F                                   | 7. Age (In yrs. <b>92</b>         | last birthday)<br>Yrs.         | If Under 1 Y<br>Months Da                           |   | 4 Hrs. 8.  | Date of Birth<br>(Month, Day,<br>06/18/ | Year)  |                          | place (State or Foreig                               |
| Maryland<br>a-f show<br>iffed at   | I Director  | Usual Residence of De 10a. State 10 MD  | cedent  b. County  Montgo                            | omery  | 1                                 | y,TownorLo                     |   |   |  |   |  | 1                        | 1 ☐ Yes 2 ☑ No                                       |
| with the   |   | 10e. Street and Numbe   |  | Rd. #210   | 17                                |                                | 10f. Zip Co   |   |  | 10                                      | og. Citizen of t                                 |                          | -  |
| permit. Pages 1 and 2 should be filed with 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed with 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral  | 11. Marital Status 1 □ Never Married 3 ☒ Widowed 4 □  | 2☐ Married   | 12. Was Deced                                    | dent Ever in U.<br>ces?<br>2 🔀 No |                                | Was Decedent<br>If Yes, specify                     | of Hispanic Orig<br>Cuban, Mexican,<br>No <i>Specify:</i> | in? (Specify<br>Puerto Rica  | Yes or No-<br>an, etc.)                 | 14. Rac  | ce - Americ              | can Indian,<br>etc.                                  |
| within 72 h<br>ene.<br>than "natu<br>he Medical  | Completed   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Home Economics Teach       |  |  |                                   |                                |   |   |  | Public Education                        |  |                          |  |
| Jid be filed<br>Aental Hygirked other<br>tic event, ti   | To Be Co  | 17. Father's Name (First Hiram Fre  |  | 1  |                                   | I                              |   | 18. Mother  | 's Name (Fi  | rst, Middle, N                          | Maiden Surnar<br>tetter                          | ne)                      |  |
| nd 2 shorth and N 27 is marr trauma  |   | 19a. Informant's Name<br>Rebecca T.   |  |  | •                                 |                                |   | reet and Number   |  |   | -  |                          | Code)  |
| nermit Pages 1 and 2 should be filed within 72 hours aft bearint. Pages 1 and 2 should be filed within 72 hours aft popertment of Health and Mental Hygiene.  mportant: If item 27 is marked other than "natural", or my Injury or other traumatic event, the Medical Exami pine.  |   | 20a. Method of Disposit<br>1 ☐ Burial 2 🕱 C<br>4 ☐ Donation 5 [   | remation 3   | _  | tate c                            | emetery, cre                   | osition (Name of<br>matory or other<br>ake Cre      | place)  | Date<br>Ap<br>20   | r 8                                     | 20c. Location Beltsv                             | -                        | own, State  Maryland                                 |
| permit. Departimports any Inj once.  |   | 21. Signature of Funeral Service ticepage  Mod 382  22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-   |  |  |                                   |                                |   |   |  |   | 0910-  |                          |  |
| ate be<br>nysicia<br>he bur  | Physician/Medical Examiner  | 23a. Part1. Enter the cashook, or heart far Immediate Cause (Findisease or condition resulting in death)  Sequentially list condition fany, leading to immediate. Enter Underlying Cause (Disease or injuntat initiated events resulting in death) Last | ailure. List onl<br>al<br>ions,<br>diate<br>ig<br>ry | b. — Due to (c                                   | ch line.                          | uence of):                     |   | R AC  |  |   | SST,   |                          | Approximate Interval Between Onset and Death MINUTES |
| ing e as   |   | IF FEMALE:<br>23b. Was decedent pro<br>in the past 12 mo<br>1 ☐ Yes 2 ☐ N<br>9 ☐ Unknown  | nths?  |  | nth 2∐Feta<br>unt at time of d    | death 3                        | ⊒Ectopic pregn<br>⊒Other (specif                    |   |  |   |  | ate of delive            | ery<br>Day Year                                      |
| w requires that be been signed by should be deta   |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ATRIAL FIBRILLATION  23e  |  |  |                                   |                                |   |   | Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown   |   |  |                          |  |
|  | Completed by  |   |  |  |                                   |                                |   |   | . Were autopsy findings availal<br>prior to completion of cause of<br>death?<br>1 □ Yes 2 No |   |  |                          |  |
| hysi<br>this c   | 25. Was case referred to medical examiner? 1   Yes   22   No  |   |  |  |                                   |                                |   | <i>y</i> )  |  |   |  |                          |  |
| To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur 28d. Describe how injury occur |   |  |  |                                   |                                |   |   |  |   |  |                          |  |
| To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b  | edical  | 29a. Certifier (Check only one)   | Certifying F  Medical Exa                            | Physician: To the laminer: On the ba<br>and mann | sis of examina                    | wledge, deat<br>tion and/or in | th occurred at to                                   | ne time, date and<br>my opinion, deat                     | d place, and<br>th occurred a  | due to the ca<br>at the time, da        | ause(s) and m<br>ate and place,                  | anner as s<br>and due to | tated.<br>o the cause(s)                             |
| To t<br>To t<br>Com  | Σ   | 29b. Signature and title  | le le le le le le le le le le le le le l             | All  | en                                | h                              |   | 2409:   | 3  | 29                                      | 9d. Date signe                                   | id (Month,               | Day, Year)   |
| 15   |   | 30. Name and address MARK PA  | of person who  | o completed cause                                |                                   | 23a) (Type,                    | Print) RACE F                                       | IFLD T  | RD S   | SILVE1                                  | e Spe  | ING                      | 8<br>MD 269  |
| Stat<br>Registra   | -   | 31. Date filed (Month   | Day, Year) 20  | 08 P. Re   | gistrar's Signa                   | ture                           | whi   |   |  |   |  |                          |  |

DHMH 17 Rev 1/2001

Registrar

|                          |   |                 | 1 - For<br>Stete<br>Registrer  | State of Maryl  |  | artment of F  |   |   | giene<br>Reg. No.   | 11893   |  |
|--------------------------|---|-----------------|--|---|--|---|---|---|---|---|--|
|                          | Physici<br>/Medic   |                 | 1. Decedent's Name (First, Middle,   | CARL  | THU  | RLOW  | -   | 2. Date of De.<br>Month<br>APNIL  | Day Year  | 3. Time of Death<br>9 12. 70 P M                |  |
|                          | Examir  |                 |  | PORTAL HOSPI  | ITAL urs. last birthday,   | HAVRE O   |   | C.C   | 4c. County of Death HARFORD   |   |  |
|                          | Funeral<br>Director   |                 | 219-38-3255 Usual Residence of Decedent  | 1 <b>X</b> □M 2□F 69  | Yrs.   | Months Days   | Hours Min.  | 8. Date of Bin<br>(Month, Da<br>07-27-  | 1938 Mai  | cyland  |  |
| d 2121                   | after deeth with the Maryland or items 23a or 28e-f show unlimiter routilies at   | Director        | 10a. State 10b. County  Maryland Hari  10e. Street and Number  |   | City, Town or L  |   |   |   | 10g. Citizen of What C  | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No country? |  |
|                          | th with   | alD             | 1307 H. Scottsda   | ale Drive   |  | 210   | 15  |   | U.S.A.  |   |  |
|                          | 72 hours after deeth with the Maryland<br>natural', or itsms 23a or 28e-f show<br>ilical Examinar must be notified at   | by Funeral      | 11. Marital Status  1 □ Never Married 2 🕅 Marrie 3 □ Widowed 4 □ Divorced  | 12. Was Decedent Ever in Armed Forces? ad 1 □ Yes - 2M No If Yes, Give Year or Dates:         | n U.S. 13.   | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 No                     |   | pecify Yes or No<br>to Rican, etc.)   | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White |   |  |
|                          | within<br>lene.<br>then   | To Be Completed | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>12   |   | (Give  | dent's Usual Occup<br>b kind of work done<br>DO NOT use retired<br>luce Manas | during most of word)  | rking   | 16b. Kind of Business Grocery                                       | s/Industry                                      |  |
|                          | 1 and 2 should be file<br>Health and Mental Hy<br>sm 27 is marked oth<br>ther traumatic svent   |                 | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)   |   |  |   |   |   |   |   |  |
|                          |   |                 | 19a. Informant's Name/Relationshi Sandy Thurlow ( 20a. Method of Disposition   | (Wife)  | 1307<br>b. Place of Disp   | H. Scott  | tsdale Di   | ber, City or Town, State, Zip Code)  1 air, MD 21015  20c. Location - City or Town, State |   |   |  |
| OE.                      | 00  |                 | 1 ABurial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp.   | 3 □Removal from State P:  | -  | matory or other place<br>Cemetery   |   | 08-2008   | Baltimore   |   |  |
| Baltimore,               | permit. Pag<br>Department<br>Important: It<br>any Injury o  |                 | 21. Signature of Funeral Service L   |   | 2  | 2. Name and Addre   | ss of Facility So   | himunek   |   | ome of BelAir                                   |  |
| Records, P.O. Box 68760, | The private reason to the private reason to | dical Examiner  | shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ( ANGU 73 N   | Interval Between Onset and Death   |   |   |   |   |   |  |
|                          | the deat certifica<br>y the attending phached for use as the  | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pre<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time of<br>9 □ Unknown | etal death 3[  | □Ectopic pregnancy<br>□ Other (specify)                                       | ,   |   | 23d. Date of de<br>Month  | blivery<br>Day Year                             |  |
|                          | w requires thet the de<br>been signed by the s<br>should be detached f  |                 | Part II. Other significant condition  ACUTE ON CHA   | ENIC RENAL  | PAILL  | ine Ti  | AUNUICE   | 101   |   | to the cause of death?                          |  |
|                          | n: The law r<br>icate has be<br>r, page 2 sh  | Completed by    | MOLETHIASIS  |   |  |   | FIRRILLAT   |   | rmed? death?  |   |  |
| Ę                        | sicia:<br>s certif  | To Be           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital: 1 Minpatient 2  | □ EB/Outpatio  | ath Check only o  | bck only one  5 Residence 6 Other (Specify)  Describe how injury occurred |   |   |   |  |
| Division of Vital        | To the Hospital or Attending Physicien: The i within 24 Hours eler death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page   |                 | 27. Manner of Death  1 Natural 5 Pending 2 Accident investiga  | 28a. Date of Injury<br>(Month, Day Year   | f 28c. Injur<br>Wor  | 28c. Injury at Work? 28d. Desc  |   |   |   |   |  |
| Divis                    | Itai or Atti<br>rs efter de<br>ral Diracto<br>led in by ti  | Certification;  | 3 Suicide 6 Could no<br>4 Homicide determin  | building, etc. (Sp.   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)           |   |   |  |
|                          | To the Hospital within 24 hours e To the Funeral Completely filled  | Medical         | 29a. Certifier 1 Certifying (Check only 2 Medical E  | Physician: To the best of my<br>xaminer: On the basis of exam<br>and manner stated.           | knowledge, deat<br>ination and/or in   | h occurred at the tin<br>exestigation, in my o                                | ne, date and place<br>pinion, death occu                                  | rred at the time,   | cause(s) and manner a<br>date and place, and du                     | e to the cause(s)                               |  |
|                          | To th<br>To th<br>comp  | W               | 29b. Signature and title of certifier  |   |  | 29c. Licens   | e number  |   | 29d. Date signed (Mon   | th, Day, Year)                                  |  |
| 7                        | 6   |                 | 200. Signature and title of certifier  201. Name and address of person w  A A A A A A A A A A A A A A A A A A  | to completed cause of death (   | Item 23a) (Type  | Print)  | 1518  | /   | 4PRIL-C   | 14-1008   |  |
|                          | 7   |                 | ALW SWEAT  | TAN HARPON  | 1351 P   | roller 1  | 4051174   | HAVR  | FBE GRACO   | - 170   |  |
|                          | Sta<br>Registr  | te<br>ar        | APR 1 1  | 2008 32. Hagistrar's Si   | griature.  | parte   |   |   |   |   |  |

**Physician** /Medical Examiner requires that the death certificate be executed burial-tran

**Physician** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural".

than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, t

the Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

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Records,

Vital

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Physician/Medical þ Completed Be Certification: To

death after death Director filled in by 24 hours a the within 2

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

29b. Signature and title of certifier

(Check only

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print)

and manner stated.

REENE STREET, BALTIMORE, MD 21201

State Registrar

2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 10. 2008 Elizabeth 08:30 AM Christine Trenchard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-05-1952 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗙 F 55 Maryland Director 212-60-6082 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 Burgess Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 [X] If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If item 27 is marked other than any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Mars Supermarket Grocery Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter J. Rutkowski Irene L Hoeniq ဂ္ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Burgess Avenue Baltimore, Maryland 21214 Mr. Charles M. Trenchard -Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition New Cathedral Cemetery 04/14/2008 Baltimore, Maryland 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road of Funeral Service L 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** UDNTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinite diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence ofy attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami al Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 200 io
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate 1 ☐Yes 2 ☐ No Division of Vital 1 □Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural n 24 hours after death.

Funeral Director: Aff 1 □Yes 2 □No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 10,2008 D64395 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHARLES ST, SUITE 209 BALTIMITE, MD 21204 DANIEUE DOBERMAN, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#8, perfet, \$2/8,4/11/08, ws. amenitem 5 per fth 9879 5-7-08 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** H:HIPM Tillman April 2008 John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GIVES 105 PITAL ALTIMOR Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1**X**M 2□ F Months **-40-1840** 64 Director 43 SC -20-Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at YY Yes 2 □ No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. "natural", or items 23a 21229 4006 West Franklin Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bert & Goodman than Elementary/Secondary (0-12) College (1-4or 5+) Print Signs llth grade na Sign Company Health and Mental Hygi em 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Tillman Lonnie Gray ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any injury or other trau-once. Terresa Tillman-Granddaughter 4330 Eldone Road, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 4/14/08 Randallstown, Md 22. Name and Address of Facility
March F/H West 21 Signature of Funeral Service Licensee Grald 21215 DAMUM. 4300 Wabash Ave, Baltimore, 3a. Part1 Enter the disease, or complications that rused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I me time Cause (Final disce or condition resulting in death) Physician a others elevatic Knows COSO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dille to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No 1∐ Yes the Hospital or Attending Physician: nin 24 hours after death, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient မ After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/5 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician atthew Fery APRIL 04:40 AM 8 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital of Baltimore Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 217-38-9079 1**2**M 2□F Director et. 10, Mainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1XYes 2 □ No Director a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or and Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or item Examiner Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 5-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Home Elementary/Secondary (0-12) College (1-4or 5+) NIA prover provement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) attheur Terr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Edgecomb Circle N. DOIL Bauto, md, 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place),

ME(N) (remail Date 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 Burial 2 remation = 5 3 □Removal from State Important: Is any Injury o once. metn remalon Department 4 Donation, 5 Dother (Specify) 22. Name and Address of Facility FredHILTUN 21. Signature Funeral Service Ligenses Balto, md, 2,229 mar ch Fit. Approximate Interval Between Onset and Death n r in disease, or complications that caused the death. Do not enter the mo it of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Immediat Cause (Final 2 days **Physician** Acute Hemorrhagic Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 years Hypertension Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 ☐ Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End-Stage Renal Disease 2 No 3 ☐ Probably 4 ☐ Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an AIDS page 2 s autopsy performed? Yes 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours a To the Funeral I (Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL, 8, 2008 RES-000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore

DHMH 17 Rev 1/2001

Registrar

Markos Kashiouris, M.D.

31. Date filed (Month, Day, Year)

APR 1 1 2008

as

Know

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EVELYN BIERLY WEISER 3 2008 APR 7:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🕅 F 193-14-5211 86 Oct.16,1921 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 910 Twinbrook Parkway 20851 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Maritai Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Bierly ပ Marie E. Leister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Twinbrook Parkway Rockville, MD 20851 19a. Informant's Name/Relationship (Type. Print) Henry Kurtz Weiser/Husband 20b. Place of Disposition (Name of competery, crematory or other place) Lutheran Reformed Church Cemetery 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 4-7-08 Rebersburg, PA 22. Name and Address of Facility Richardson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 29 South Enola Drive, Enola, PA enny Jell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an

**Physician** /Medical **Examiner** 

**Funeral** 

**Director** 

"natural", or items 23a or 28a-f show dical Examiner must be notified at

than

other

Pages 1 and 2 should be fill iment of Health and Mental Heart: If item 27 is marked of

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.

the

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

attending physician and for use as the burial-tran signed by s certificate has b lirector, page 2 s 24 hours after death.

• Funeral Director: After this certifical letely filled in by the funeral director, Be 2 Certification:

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

autopsy 2 🔽 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of

0101235221 (VA)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 🛚 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2008 APRIL. 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MC LCDR JOON S. YUN USN

Hospital:

1 XInpatient

28a. Date of Injury (Month, Day Year)

and manner stated

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

Medical

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

determined

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITMET per H. (2878, 4/23/08 WS)

State of Marytand / Department of Health and Mental Hygiene 2 0 0 8

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 9, Erma Ruth Wagner 9:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Longview Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2XXF 216-07-9265 89 -Director 9, Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!, or items 23s or 28s-1 show ery injury or other treumatic event, the Madical Examiner. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1007 Harmont Road 21228 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3rd Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Heidel, Jr. Ethel (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3693 Clydesdale Road Way, Reisterstown, MD 21136 Gerard B. Wagner, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) April 14, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2008 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Eckhardt Funeral Charel, P.A.

3296 Charmil Drive, Manchester, Maryland 21102 Part / En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the artifallure. List only one cause on each line. Approximate Interval Between Onset and Death Immedine Cause (Final disease or condition resulting in death) Alzhaires Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine After this certificete has been signed by the attending physicien and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 2 Yes 2 No Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 51705 DR Hestminster MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 349 m. PANSURIYE mal colm 31. Date filed (Month, Day, Year) APR 11 32. Pojistrar's Signature State 2008 mel Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

|  |  |   | r Print in Black   |                  |  |  | -                                      |  | gible.                            |  |
|--|--|---|--|------------------|--|--|--|--|-----------------------------------|--|
|  |  | 1 _ State   | of Maryland / D  |                  | artment of H<br><i>rtificate of L</i>                            |  | lental Hy                              | 21   | 000                               | Honn   |
|  | -  | Registrar  1. Decedent's Name (First, Middle, Last)   |  | Cer              | inicate of L   | Jean —                                     | 2. Date of De                          | Reg. No.                                     | 000                               | 3. Time of Death                                   |
| Physici  |  | Charles Richard Wolfor  | rd.  |                  |  |  | April                                  | 9, Day 2                                     | 008 <sup>ear</sup>                | 5:45 P M   |
| /Medio<br>Examin   |  | 4a. Facility Name (If not institution, give street and  | number)  |                  | 4b. City, Town, or   | Location of Death                          |  |  | nty of Death                      |  |
|  |  | 307 Wakefield Place   |  |                  | Bel Ai   |  |  | Har  | ford                              |  |
| Funeral<br>Director  |  | 5. Social Security Number 6. Sex 214-24-1750 1№ 2□F   | 7. Age (In yrs. last birti   | hday)<br>(rs.    | If Under 1 Year Months Days                                      | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Bir<br>(Month, Da<br>July 3 | v Vear                                       | 9. Birthpl<br>Count<br>West       | lace (State or Foreign<br>try)<br>Virginia         |
| and ww   |  | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town  | or Lo            | cation   |  |  |  | 10                                | Od. Inside City Limits                             |
| Maryl<br>f sho   | tor  | Maryland Harford  | Bel Ai   | r                |  |  |  |  |                                   | 1 ☐Yes 2 XNo                                       |
| h the<br>r 28a<br>noti   | Director   | 10e. Street and Number  | DOI 111  |                  | 10f. Zip Code  |  |  | 10g. Citizen                                 | of What Coun                      | try?   |
| tth wil  |  | 307 Wakefield Place   |  |                  | 21014  |  |  | USA  |                                   |  |
| er dea<br>tems<br>ter m  | Funeral  | Armed   | ecedent Ever in U.S.<br>Forces?  | 13. V            | Was Decedent of Hi<br>f Yes, specify Cuba                        | ispanic Origin? (Sp<br>in, Mexican, Puerto | ecify Yes or No<br>Rican, etc.)        | )- 14. F                                     | Race - America<br>Black, White, e |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by   | If Yes,   | r Dates:   |                  | 1□Yes 2⊠No   | Specify:                                   |  | Spe  | <sup>city:</sup> Whi              | te   |
| n 72 h<br>"nati  | Completed  | 15. Decedent's Education<br>(Specify only highest grade complete  | (d) 16a.   | Deced<br>(Give I | lent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | ation<br><i>furing most of worl</i>        | king                                   | 16b. Kind of                                 | f Business/Ind                    | ustry  |
| withi<br>iene.<br>than   | dwo  | Elementary/Secondary (0-12) College   | 9 (1-4or 5+)   |                  | rement   | ,  |  | Auto   | Sales                             | & Service  |
| e filed<br>al Hyg<br>other   | Be C   | 17. Father's Name (First, Middle, Last)   |  |                  |  | 18. Mother's Nam                           | e (First, Middle                       | <u>.                                    </u> |                                   |  |
| wuld by<br>Menta<br>arked  | ToE  | Jethro A. Wolford   |  |                  |  | Myrtle S                                   | . Snyde                                | er   |                                   |  |
| 2 sho<br>and<br>is ma  |  | 19a. Informant's Name/Relationship (Type. Print)  | 19b.   | Mailin           | g Address (Street a  | and Number or Ru                           | ral Route Numb                         | er, City or To                               | vn, State, Zip                    | Code)  |
| 1 and<br>Health  |  | Phillip D. Kilby / Atto   | orney 11:  | 2_W              | lest Penns   |  | Ave., E                                |  | Mary                              | land 21014   |
| ages<br>int of it: If ite  |  | 1 Burial 2 ☐ Cremation 3 ☐ Removal fro  | m State cemeter)   | v, cren          | natory or other plac<br>iemorial                                 | e) ¦                                       |  | Bel Ai                                       | ,                                 | ,  |
| nit. Partme  |  | 4 □ Donation 5 □ Other (Specify)  21. Signature of uneral virice Licensee   | 1  | -                | Name and Addres  |  |  |  | r, recr                           | yrana  |
| Dep Dep any  |  | Marke dans  | 1  | 13               | 17 Cokech  | NINT PORG                                  | Ahino                                  | rdon M                                       | arvlan                            | d 21009  |
| Physician<br>/Medical<br>Examiner  |  | resulting in death)   | caused the death. Do not neach line.  On gestive to (or vacconsequence or          | ot ente          | er the mode of dying   | g, such as cardiac                         | or respiratory a                       | rrest,                                       |                                   | Approximate<br>Interval Between<br>Onset and Death |
| be executed iician and burial-transit  | al Examiner  | cause. Enter Underlying Cause (Disease or injury that initiated events c.   | to (or as a consequence of   |                  |  |  |  |  |                                   |  |
| ficate<br>phys<br>s the  | edic   | d   |  |                  |  |  |  |  |                                   |  |
| The law requires that the death certificate b tte has been signed by the attending physic bage 2 should be detached for use as the b   | Physician/Medica   | in the past 12 months?  | outcome pf pregnancy<br>e birth 2  Fetal death<br>egnant at time of death<br>known |                  | Ectopic pregnancy<br>Other <i>(specify)</i>                      |  |  |  | Date of delive<br>Month           | ry<br>Day Year                                     |
| s that   | by Ph  | Part II. Other significant conditions contributing to   | death but not resulting in   | the un           | iderlying cause give   | en in Part I.                              | 23e. Did 1                             | tobacco use c                                | ontribute to th                   | e cause of death?                                  |
| equire<br>en sig   | ed b   | Prosthetic Mitra  | 1 Value  | -                |  |  | 1 🗆                                    | Yes 2□ No                                    | 3 ☐ Proba                         | ably 4 Unknown                                     |
| The law re<br>ate has bee  | Completed  |   |  |                  | -  |  | 24a. Was<br>auto<br>perfo              |  | prior to con<br>death?            | osy findings available<br>npletion of cause of     |
| ctor, I  | Bec  | 25. Was case referred to medical examiner?  |  |                  |  | 26. Place of Deat                          |  |  | 12,100                            |  |
| hysic<br>this co   | ို   | 1 ☐ Yes 2 No Hospital: 1  | ☐ Inpatient 2 ☐ ER/Outp  |                  |  | 4 LI Nursing Ho                            |  | dence 6 🗆                                    | - ' '                             | ")   |
| Jing P   | ion:   | 1 Natural 5 ☐ Pending (M  | te of Injury 28b. Ti<br>onth, Day Year) Inj  | me of<br>jury    | 28c. Injury<br>Work<br>M 1 □                                     | / at<br>:?<br>Yes 2 □ No                   | 28d. Describe                          | how injury occ                               | curred                            |  |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | Suicide   Suic |   |  |                  |  |  |  |  | Route Number,                     |  |
| the Hospit<br>in 24 houn<br>the Funer<br>pletely fille   |  |   |  |                  |  |  |  |  | ated.<br>the cause(s)             |  |
| With Too   | 2  | 29b. Signature and title of certifier   | MO   |                  | D OC   | 3925<br>7acPha                             | 78                                     | 29d. Date sig                                | ned (Month, I                     | 2008   |
| 441  |  | 30. Name and address of person who completed call by the state of the | ause of death (Item 23a) (T<br>A A A A A A A A A A A A A A A A A A A               | ype, F           | 15 W, K  | TacPha                                     | 11#2                                   | 06 1   | Bel Ai                            | - MD.  |
| Sta  |  | APR 1 1 2008  | . Hegistrar's Signature  | 200              | SAA D  |  |  |  |                                   |  |

| DIVISION OF VICAL DECORDS, F.O. DOA 007 00,   |     | Daiminore, Maryland 21213                      |
|---|-----|--|
| al or Attending Physician: The law requires that the death certificate be executed    | ā   | p _ d  |
| after death.  | i   | Department of Health and Mental Hygiene.       |
|   | Ď.  | Important; If item 27 is marked other than "ni |
| d in by the funeral director, page 2 should be detached for use as the burial-transit | 100 | any injury or other traumatic event, the Media |

| Phyllis Whitaker Warren  4a. Facility Name (if not /misturize) groups and number)  4b. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town, or Location of Devath  4c. City, Town or Location  4c. Courty of Death  4c. Courty of Death  4c. Courty of Death  4c. City, Town or Location or Indied City Li  1co. State  1co. State  1co. Courty  1co. State  1co. City, Town or Location  1co. City, Town or Location  1co. State  1co. City, Town or Location  1co. State  1co. City, Town or Location  1co. State  1co. City, Town or Location  1co. State  1co. City, Town or Location  1co. State  1co. City, Town or Location  1co. City, City, May Or City, City, May Or City, City, May Or City, City, May Or City, Cit |           | 1 - For State Registrar   | State of Maryla                                  | ind / Depa<br><i>Cei</i>              | artment of F<br>rtificate of                  | lealth and N<br>Death                     |                                       | giene 2<br>Reg. No.        | 2008                          | 3 1190   |
|--|-----------|---|--|---------------------------------------|---|---|---------------------------------------|----------------------------|-------------------------------|--|
| 46. Facility Name of Inceptations on we agreed and managed Centre or 230-44-3822 Library 10-50 epit (1994) 10-50 epit (1 |           |   |  |                                       |   |   | 2. Date of De<br>Month-R              | ath<br>IL <sup>Day</sup> B | . ZM                          | 3. Time of Deat 8 01:26 F                          |
| 230 - 44 - 382   |           | 4a. Facility Name (If not institution, give                                   | e street and number)<br>Medical Ce               | nter                                  | 4b. City, Town, o                             |   | on                                    | 4c. Co                     | ounty of Deat                 | timore   |
| South   100. Country   100. City Province   100.    |           |   |  |                                       |   |   | 8. Date of Birl<br>Month Da<br>May 2, | <sup>h</sup> 1935          | 9. Birt<br>Co<br>Ke           | untry)   |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI |           |   | 10c. 0   | City, Town or Lo                      | cation  |   |                                       |                            |                               | 10d. Inside City Lin                               |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI | ctor      | MD  |  | Baltin                                | more  |   |                                       |                            |                               | 1 X Yes 2□   |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI | Direc     |   |  |                                       |   |   |                                       | _                          |                               | untry?   |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI | eral      |   |  | 11.0                                  |   |   |                                       |                            |                               | doon Indian  |
| 23a. Part I. Enter the disease, or complications that caused the delim. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finite-via Blanch interval Blanch  | 5         | 1 ☐ Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give        |                                       | If Yes, specify Cuba                          | an, Mexican, Puerto                       | ecity Yes or No<br>Rican, etc.)       |                            | Black, White                  | e, etc.  |
| 23a. Part I. Enter the disease, or complications that caused the delim. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finite-via Blanch interval Blanch  | eted      |   |  | i (Give                               | kind of work done                             | durina most of work                       | 16b. Kind of Business/Industry        |                            |                               | Industry   |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI | dmo       | Elementary/Secondary (0-12)   | College (1-4or 5+)                               | 1                                     |   |   |                                       | Heal                       | lth Car                       | ^e   |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI |           | 17. Father's Name (First, Middle, Last)                                       | )  | 1 3                                   |   |   | e (First, Middle,                     |                            |                               |  |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI | To B      | Floyd Whitaker  |  |                                       |   | Bertha                                    | a Wood                                |                            |                               |  |
| 23a. Part I. Enter the disease, or complications that caused the desirn. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finterval Ballwess interval and cause (Pinal resulting in death)  ACUTE STROKE  Due to (or as a consequence of):  ACUTE RENAL FAILURE  Due to (or as a consequence of):  ACUTE RENAL FAI |           | Cheryl Barrows/   | Daughter   | 31 8                                  | Brett Man                                     | or Court                                  | , Hunt V                              | alley                      | , MD                          | 21030  |
| 23a. Part I. Enter the disease, or complications that caused the distin. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate finite-via Barbara finite-v |           | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🔀 Other (Specif                   | Removal from State Duy Mausoleum                 | cemetery, cret<br>Taney V<br>ausoleur | matory or other plac<br>alley<br>n            | 04/1                                      | 11/2008                               | T                          | Γimoniu                       | um, MD   |
| ACUTE STROKE    Immediate Cause (Final resulting in death)   Acute   A | 5         | 21. Signature of Funeral Service Licer  |  | 22                                    | 2. Name and Addre                             | ss of Facility Ruc<br>rk Road,            | ck Towson,<br>Towson,                 | n Fun<br>MD                |                               | Home, Inc.   |
| Due to (or as a consequence of):  Cause Disease or Injury instituting in death) Last  Due to (or as a consequence of):  Cause Disease or Injury instituting in death) Last  Due to (or as a consequence of):  Cause Disease or Injury instituting in death) Last  Due to (or as a consequence of):  C. Due to (or a |           | shock, or heart failure. List only<br>Immediate Cause (Final                  | one cause on each line.                          |                                       | er the mode of dyir                           | ng, such as cardiac                       | or respiratory a                      | rrest,                     |                               | Approximate<br>Interval Betweer<br>Onset and Death |
| Due to (or as a consequence of):  d.    FEMALE:   230. Was decedent pregnant in the past 12 grooths?   1   1   1   1   1   1   1   1   1   |           |   |  |                                       | ILURE   |   |                                       |                            |                               |  |
| Due to (or as a consequence of):  d.    FEMALE:   230. Was decedent pregnant in the past 12 grooths?   1   1   1   1   1   1   1   1   1   | niner     | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons                             | equence of):                          |   |   |                                       |                            |                               |  |
| FFEMALE:   23b. Was deceled pregnant in the past 12 months?   1  |           | that initiated events resulting in death) Last                                | C Due to (or as a conse                          | equence of):                          |   |   |                                       |                            |                               |  |
| FFEMALE:   23b. Was deceled pregnant in the past 12 months?   1  | edica     |   | _d   |                                       |   |   |                                       |                            |                               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of the total to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, death and place, and due to the cause of the time, | sician/M  | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 No          | 1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of | etal death 3                          |   | /   |                                       | 230                        |                               |  |
| 25. Was case referred to medical examiner?   | b         |   | contributing to death but not re                 | esulting in the u                     | nderlying cause giv                           | en in Part I.                             |                                       |                            |                               | \  |
| 25. Was case referred to medical examiner?   | omplete   |   |  |                                       |   |   | autor<br>perfo                        | rmed2                      | prior to death?               | completion of cause                                |
| 1  |           |   |  |                                       |   | 26. Place of Deat                         |                                       |                            | 7                             | -74  |
| 1 Natural 2 Accident 3 Suicide 4 Homicide   5 Pending investigation 6 Could not be determined   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature   29d. Date filed (Month, Day, Year)   29d. Registrar's Signature     | 2         | 1 ☐ Yes 2 No  | 1 Minpatient 2                                   |                                       | IL SU DOA                                     | 4 Linursing Ho                            |                                       |                            |                               | cify)  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHOSROW TABASSI, M. D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | tion:     | 1 Natural 5 ☐ Pending   | (Month, Day Year)                                |                                       |   |   | ∠ou. Describe l                       | iow injury o               | occurred                      |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHOSROW TABASSI, M. D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | Sertifica | 3 Suicide 6 Could not be  | 28e. Place of injury - At                        | home, farm, str<br>cify)              |   |   | 28f. Location (S<br>City or Tox       | Street and f<br>vn, State) | Number or Ru                  | ural Route Number,                                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHOSROW TABASSI, M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |           | (Check only 2 Medical Exam  | niner: On the basis of exami                     | nowledge, death<br>nation and/or in   | n occurred at the tir<br>vestigation, in my o | me, date and place<br>opinion, death occu | , and due to the<br>rred at the time, | cause(s) ar<br>date and pl | nd manner as<br>lace, and due | s stated.<br>e to the cause(s)                     |
| KHOSROW TABASSI, M.D. 76Ø1 OSLER DRIVE TOWSON, MARYLAND 212Ø4  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | Me        | 29b. Signature and title of certifier   | t  |                                       |   |   |                                       | 29d. Date s                | signed (Mont                  | h, Day, Year)<br>2008                              |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |           |   |  |                                       |   | VE TOW                                    | SON, MA                               | RYLA                       | ND 21                         | 204  |
|  |           | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sig                              | nature                                | AP .  |   |                                       |                            |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #7&8 Per FH G8784/16/08 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 04 10 ay 2008 Turner Williams 2:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Nursing & Rehabilitation Center Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 237-30-0667 13€ M 2 ☐ F 99 -97. Director NC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 501 West Franklin Street 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 25 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 🙀 No Specify. δ SpecifyBlack 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) laborer Bethlehem Steel traumatic event. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be David Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Morrison / Grandson 198 Morris Hill Avenue; Baltimore, MD 21060 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/2008 Baltimore, Maryland Metro Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only orle cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheloscleeofic ears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has page certificate 2 X No 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Certification: 27, Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3215X 68

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

yotin

31. Date filed (Month, Day, Year)
APR 1 1 2008

Pari

Law St, STE 467.

Balti more

who completed cause of death (Item 23a) (Type, Print)

MI

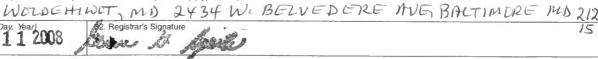
821 N. EL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vear 550AM ,2008 Joselyn Marie Williams APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a BALTIMORE LEVINDALE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country Prinidad Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 55 1□M 2X F Yrs. Director 215-74-2970 12-3-1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Director Baltimore Windsor Mill 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 'natural", or Items 23a 13 Liberty Place, Apt. 3B 21244 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23s by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) Dietitian 12th 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) Myrna Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa E. Harrison/Daughter 8121 Subet Road, Windsor Mill, MD 21244 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Lakeview Memorial Cemetery 4-16-08 Sykesville, MD Signatur Funeral Service Licensee 22. Name and Address of Facility Whie Funeral Home P.A. of Baltimore Co. 570 redone 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ERI PHERAL ARTERIAL DESEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MD STHGE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H. WorstHING D0063327 APRIL 07, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Day, Year) 1 1 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                   |  |                   | For State Registrar   | State of Maryland / Depa   | rtment of Health and tificate of Death   | Mental Hygie   | 4000                                     | 11904  |
|-------------------|--|-------------------|---|--|--|--|--|--|
| ,                 | Physic<br>/Medi  |                   | Decedent's Name (First, Middle, L   | WHIDEMANN  |  | 2. Date of Death                                     | Day Year<br>5 200                        | 3. Time of Death 8 926 PM                                  |
|                   | Examil<br>Funeral<br>Director  | ner               | 4a. Facility Name (If not institution, g  LAPE  5. Social Security Number  6.  19228749  Usual Residence of Decedent  | Sax 2 F F Yrs.   | 4b. City, Town, or Location of Dea  BALT MOR  If Under 1 Year If Under 24 Hrs  Months Days Hours Min                       | 8. Date of Birth                                     | 4c. County of Deal  N/A  9. Birl  1924 M | tholace (State or Foreign ountry)                          |
|                   | e Maryland<br>Be-f show  | ctor              | 10a. State 10b. County  | 10c. City, Town or Loc   | eation (timore   |  |  | 10d. Inside City Limits 1 Yes 2 □ No                       |
|                   | s 23a or 26  | Funeral Director  | 2121 Windsor  | - Garden Lane  | 10f. Zip Code 2 ( 20 7   |  | Citizen of What Co                       | SA   |
| 5-0036            | 72 hours after death with the Maryland natural", or items 23a or 28e-f show deat Extrating the footfred at   | þ                 | 11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced   | 1 X Yes 2 No (445 -  | Vas Decedent of Hispanic Origin? (5 Yes, specify Cuban, Mexican, Puel   Yes 2 No Specify:                                  | Specify Yes or No-<br>to Rican, etc.)                | 14. Race - Ame<br>Black, Whit            |  |
| 21215-0           | within<br>ene.<br>than   | Completed         | 15. Decedent's (Specify only highest g  | College (1-4or 5+)   | ent's Usual Occupation<br>kind of work done during most of wo<br>O NOT use retired)  Che  Che  Che  Che  Che  Che  Che  Ch | elina -  | 3/ue C<br>Restau                         | rest   |
| land              | ould be filed<br>Mental Hygi<br>arked other<br>atic evant, I   | To Be (           | 17. Father's Name (First, Middle, Las   | ihide mann   | 18. Mother's Na  | me (First, Middle, Maid                              | den Sumame)                              | deis   |
| , Mary            | 1 and 2 should<br>Health and Men<br>am 27 Is marke<br>ther treumatic   |                   | 19a. Informant's Name/R lationship Eric Bun   | dy - nephew 3360   | Address (Street and Number or R  | urai Route Number, Ci                                |  | 1 1/   |
| more              | permit. Pages 1 and<br>Department of Health<br>Importent: If itam 27<br>any injury or other tr<br>2000.  |                   | 20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3  1 □ Donation 5 □ Other (Special Control of the Control |  |  |  | Location - City or<br>WINGS; n           |  |
| Baltimor          | permit. Pages<br>Department of<br>Importent: If it<br>any injury or o  |                   | 21. Signature of Juneral Service Lic  |  | Name and Address of Facility   | 270 Fred   | HILTON                                   | Pass   |
|                   | Pnysician  | 0                 | 23a. Part . Engl the disease, or conshock or heart failure. List on Immediate Lause (Final disease or condition   | nplications that caused the death. Do not enter one cause on each line.  | r the mode of dying, such as cardia  | c or respiratory arrest,                             | to.md,                                   | Approximate<br>Interval Between<br>Onset and Death         |
|                   | /Medical<br>Examiner   |                   | resulting in death)   | Due to (or as a consequence of):   | Oste, Disc   | au   |  |  |
|                   | uted<br>d<br>ansit   | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (or as a consequent e of):  |  |  |  |  |
| 8760,             | ate be executed hysician and he burial-transit   |                   | resulting in death) Last  | Due to (or as a consequence of):   |  |  |  |  |
| 9                 | eath certificate<br>attending phys<br>for use as the   | /Medi             | IF FEMALE:  | 23c. If yes, outcome of pregnancy  |  |  |  |  |
| P.O. Box          | at the death<br>by the atten<br>tached for u   | Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | 1 Live birth 2 Fetal death 3 □   | Ectopic pregnancy<br>Other (specify)   | ·  | 23d. Date of del<br>Month                | Day Year   |
|                   | The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | by                | Part II. Other significant conditions   | contributing to death but not resulting in the un  | derlying cause given in Part I.  | 23e. Did tobacc                                      |  | the cause of death?  |
| of Vital Records, |  | Completed         |   |  |  | 24a. Was an autopsy performed 1 Yes 2 3              | ? prior to death?                        | topsy findings available<br>completion of cause of<br>2 No |
| f Vit             | ysicien:<br>is certific<br>director,   | To Be             | 25. Was case referred to medical examiner?  1 Tes 2 No  | Hospital: 1 Inpatient 2 ER/Outpatient  | 000  | ath <i>Check onl</i> one<br>Home 5 Residence         | e 6 □Other (Spe                          | cifv)  |
| sion o            | Attending Physicien: r death. ector: After this certification in the funeral director, is  |                   | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   |  | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No  | 28d. Describe how in                                 |  |  |
| Division          | - 9  | Certification:    | 3 Suicide 6 Could not l   |  | et, factory, office  | 28f. Location (Street<br>City or Town, St            |  | iral Route Number,   |
|                   | To the Hospitel or within 24 hours after To the Funerel Dir completely filled in   | Medical           | 29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe  | hysician: To the best of my knowledge, death<br>miner: On the basis of examination and/or inve<br>and manner stated. | occurred at the time, date and place<br>estigation, in my opinion, death occu  | e, and due to the cause<br>urred at the time, date a | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                                 |
|                   | To th<br>To th<br>comp   | Me                | 29b. Signature and title of certifier   | M 12   | 29c. License number D3(4)4   | 29d. I   | Date signed (Month                       | n, Day, Year)  |
| 1                 | +1   |                   | 30. Name and address of person who  | completed cause of death (Item 23a) (Type, P   | rint)  | 4  | 77/10                                    | <u>C</u>   |
| 7                 | Sta  | to.               | SHOAIIS A HAT   | MI MD & 21 N. E  | MTAW IZ WATTH  | te 308, C  | BLTIME                                   | NEMD 2126  |
|                   | Registr  |                   | APR 1 1 200   |  | 2  |  |  |  |

or Print in Black Indelible Ink. Ensure All Copies Are Legible.
ID TTPM/8,17,18, perFH C3/8,4/28/08,WS
te of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 400 A M Zaranski 2008 F. 11 Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale BalTimore If Under 1 Year | If Under 24 Hrs. | If Under 1 Year | If Under 24 Hrs. | If Under 24 Hrs. | If Under 1 Year | If Under 24 Hrs. | If Under 1 Year | If Under 24 Hrs. | If Under 1 Year | If Under 24 Hrs. | If Under 1 Year | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M & □ F Director 218-03-0187 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 21237 U.S.A. 7901 33'rd. Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rubber Products NA <u>Factory Worker</u> 7 Is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname)

Mary Szczeszek 17. Father's Name (First, Middle, Last) Andy Jankowiak Jankwiak ျ -Unknown-19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Robert E. Woolsey (Nephew)
20a. Method of Disposition 7901 33'rd. Street Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 12, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Inc. 2008 Baltimore, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. W 23a. Part1. Enter the disease, or complications, nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1005 Dundalk Ave. Baltimore, Maryland 21224 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. if yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 difficile 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? /es 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 066306 4-11-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar OR SAMOUTHO DREYER

APR 1 1 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ARGASK

4000 FRANKLIN Square

32. Regutrar's Signature

DR

Balto

md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0020 M **Physician** JAMES M. ANDERSON, JR. arch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** al Eask STON If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year Age (In yrs. last birthday, Social Security Number **Funeral** 1**X**M 2□ F Months Davs Hours PA 80 MAR 22, 1927 204-18-5168 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 Yes No Director MICHAELS MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be USA 24828 DEEP WATER PT DR. 21663 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify: WHITE ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 뢽 MECHANICAL CONTRACTOR CONSTRUCTION 27 Is marked other ar traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Pages 1 and 2 should be nent of Health and Mental MILDRED DUNCAN JAMES MACFARLAND ANDERSON, SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24828 DEEP WATER PT DR., ST. MICHAELS, MD 21663 GEORGIANNA M. ANDERSON/WIFE Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State BALA CYNWOOD, PA WEST LAUREL HILL CEM: 3/22/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERON 200 S. HARRISON ST., EASTON, MD 21601 CHOL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): Examiner euroni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of) Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Ö ed by the a 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? signed b Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has , page 2 s autopsy perform death? 1 ∐ Yes 2 No 1☐ Yes 2 No certificate 26. Place of Death Check onl one 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2×No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA မ funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After ospital or Attending I Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier bo, M.D 99 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 South Was

State Registrar

31. Date filed

9 Year) (

2008

DHMH 17 Rev 1/2001

ORIGINAL

. Registrar's Signature

08-02628 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jacob Lawrence Arason State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day April 3, 2008 Medical Examiner Jacob L. Arason 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director Months Days 212-25-3002  $_{1}X$ 20 Dec. 11, 1987 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 707 Glendon Ave. 21403 USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married Armed Forces? 2 White, etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: ģ Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done permit. Pages 1 and 2 should be filed within 72 hou Department of Iteath and Mental Hygiene. Important: If item 27 is marked 1... injury or other Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Cook 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jon Arason Jane Healy 19a. Informant's Name/Relationship (Type, Print) Jon Arason Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory 4/8/2008 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty 12 Ridgely Ave. Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. /Medical Alcohol and narcotic intoxication Immediate Cause (Final disease 'Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical 3 physician 2 5 the burial -X UNPENDED #25a,27,28a-f, perME, C879 5/8/08 TT Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Completed of Vital Records, 24a, Was an certificate has be ector, page 2 sh autopsy performed? death? ✓ Yes 2 No 1 🗸 25. Was case referred to medical Be 26.Place of Death (Check only one) Other<sub>4</sub> Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 V Yes Nursing Home 5 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Fnd 4/3/2008 Fnd 5:25 am 2 Accident unk Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide

White 16b. Kind of Business/Industry Restaurant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
707 Glendon Ave. Annapolis, MD 21403 20c. Location - City or Town, State Baltimore, MD lardesty Funera Home, Annapolis, MD 21401 Approximate Interval Between Onset and Death Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi Certification: d in by the f 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be or Town, State)
707 GLendon Ave. Annapolis, MD (Specify) house Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 4, 2008 30. Name an address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) APR 0 8 2008 State gistrar's Signatur Registrar DHMH 17 Rev 1/2001 ORIĞINAL OCME **OCME 2006** 

0627 hrs

10d. Inside City Limits

1 Yes 2XXNo

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dale E Ammeson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 30, 2008 1400 hrs Medical Examiner Dale E. Ammeson c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Frederick** Woods at 9129 Slate Quarry Road Dickerson 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. **Funeral** Months Days Director Hours Country) Illinois Feb. 16, 1956 387-60-4423 52 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 X Yes 2 No or 28a-f show Washington, DC DC None 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 20016 USA 5023 Sherier Place, NW Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Specify: White 1 Yes 2 X No specify: Widowed Divorced If Yes, Give Yea \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Viking Contracting Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Corporation 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur E. Ammeson Evelvn Jacobsen Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5023 Sherier Pl., NW., Washington, DC 20016 Kim R. Ammeson/Wife 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) XBurial 2 Cremation 3 Removal from State National Memorial Pk April 5,08 Falls Church, Va. Other Specify: Denation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 Approximate Interval Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. 'Medical Death a. Hanging Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c, If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknowr contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject hanged self FOUND: Natural 1 Yes 2 V No 5 Pending Mar 30, 2008 1400 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) Woods at 9129 Slate Quarry Road, Dickerson, MD determined (Specify) Woods Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 31, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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08-02507

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| Medical Examiner  Medical Exa  | veronica Allei                       |             |  | - For State<br>Registrar                | 31               | ate of Mary                       | anu /       |            |               | of Dea         |              | i wen       | tai riygie     |              | g. No.             | 00        | 8 119                                  | 0        |
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| S. Section Security Number    String    | r \                                  |             |  | · | 11               |                                   |             | æ A        | riei          | 4b. City,      | Town, or I   | ocation o   |                | arch 30,     |                    | of Death  | 10001110                               | $\dashv$ |
| State   County   Co   |                                      |             |  | Prince Georg                            | ge Hospit        | al Center                         |             |            |               |                | verly        |             |                |              |                    |           |  |          |
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| Prince George's Cheverly   16,75c code   100,002ce of White Country   100,002ce of White Country   100,002ce of Whi   | , u                                  | 7           | -                                      |   |                  |                                   | 1           | 0c. Citv.  | Town or Lo    | cation         |              |             |                |              |                    |           | 10d. Inside City Limit                 | s        |
| 22. Name and Address of Facility 261 7 Penn Ave SE Washington DC 20020  23a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications that caused the death. Do not onsert the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time.  25a. Part. Enter the disease, or complications on the cause of death or conditions.  25b. Was decedent pregnant in the page of the page of the cause of death or p | *                                    | 9           | _                                      | MD                                      | Princ            | e George'                         | s           | Chev       | erly          |                |              |             |                |              |                    |           | 1 X Yes 2 N                            | 0        |
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| Physician (Modical Xaminer Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease)  Sequentially list conditions, francy in death)  Sequentially list conditions, francy in death of the conditions of the condition resulting in death)  Due to (or as a consequence of):  AMENDED  FEMALE:  23b. Was decedent pregnant in the past 12 months?  The past 12 mont | limo<br>Pager<br>ment o              | or of       | 1                                      | 4 Donation 5                            | Other S          | pecify:                           |             | Li         |               |                |              |             |                | 800          | Suitla             | nd M      | D                                      |          |
| Seventially list conditions   Seve   | Balt<br>permit<br>Depart<br>Impor    | injury      |  | 21. Signature of Fun                    | eral Service     | Licensee                          | Q           | 00         |               |                |              |             |                | hingt        | on DC 20           | 0020      |  | ò        |
| Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate cause (Closesso or injury that initiated each)  Sequentially list conditions, first, leading to immediate each can be considered each)  Sequentially list conditions, first, leading to immediate each can be considered eac |                                      |             | 1                                      |   |                  | on each line.                     |             |            |               |                |              |             | ardiac or resp | iratory arre | est, shock, or hea | art       | Approximate Interv<br>Between Onset an |          |
| Sequentially list conditions, if any, leading to immigrate the Cheek certifying physical part is of the contribution of the cause of the contribution of the cause of the caus |                                      |             |  |   |                  |                                   |             |            |               | complic        | cation       | S           |                |              |                    |           | Death                                  | _        |
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| With the part of t |                                      |             |  | cause. Enter Under                      | lying Cause      |                                   | a conseq    | uence of   | f):           |                |              |             |                |              |                    |           |  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   1   yes 2   No 3   Probably 4   Vunking and prior to completion of caudesth?   1   yes 2   No   1    | cuted                                | transit     | EXal                                   |   |                  | ,                                 | a conseq    | uence of   | f):           |                |              |             |                |              |                    |           |  |          |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   1   yes 2   No 3   Probably 4   Vunking and prior to completion of caudesth?   1   yes 2   No   1    | 876<br>tificate                      | as the      | 2                                      | 3b. Was decedent p                      |                  | 23c. If yes                       | , outcome   | of preg    | nancy         |                |              | _           | c pregnancy    |              |                    | -         |  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   1   yes 2   No 3   Probably 4   Vunking and prior to completion of caudesth?   1   yes 2   No   1    | OX 6<br>sath cer                     | or use      | SICIO                                  |   |                  | '   '                             |             | me of de   | - 41-         | Other (Sp      | ecify)       |             |                |              |                    |           |  | 118      |
| 29b. Signature and title of certifier  The obey M. Henry My arch 29c. License number O.C.M.E.  OCME  29d. Date signed (Month, Day, Year) March 31, 2008  | O. B<br>it the de                    | ached       |  |   |                  | 9 OIK                             |             | out not re | esulting in t | he underlyin   | ng cause g   | iven in Pa  | art I.         | 23e. Did to  | bacco use contri   | ibute to  | the cause of death?                    | -        |
| 29b. Signature and title of certifier  The obey M. Henry My arch 29c. License number O.C.M.E.  OCME  29d. Date signed (Month, Day, Year) March 31, 2008  | s, P. (ires that signed              | t be del    |  |   |                  |                                   |             |            |               | ·              |              |             |                | 1 Yes        | 2 No 3             | Prob      | ably 4 🗹 Unknown                       | 1        |
| 29b. Signature and title of certifier  The obey M. Henry My arch 29c. License number O.C.M.E.  OCME  29d. Date signed (Month, Day, Year) March 31, 2008  | ords<br>w requ                       | luoks 2     | ) Jet                                  |   |                  |                                   |             |            |               |                |              |             |                | autop        | sy p               | rior to c |  |          |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) March 31, 2008  | Rec<br>The 1s                        | bage        |  |   |                  |                                   |             |            |               |                |              |             | 1              | <b>✓</b> Yes | 2 No 1             |           | s 2 No                                 |          |
| 29b. Signature and title of certifier  The solution Mr. There The same of the signed (Month, Day, Year)  O.C.M.E.  29c. License number O.C.M.E.  Aarch 31, 2008  | <b>Ital</b><br>sician:               |             | ין<br>מ                                | examiner?                               |                  |                                   | Inpatient   | 2 🗸        | FR/Outnat     | ient 3         |              |             |                |              | Residence 6        | Other     |  | _        |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  OGME  29d. Date signed (Month, Day, Year) March 31, 2008  | of V<br>ng Phy<br>Merth              | 를   F       | -                                      |   |                  | 28a. Dat                          | •           |            |               |                |              |             | ? 28d.         | Describe I   | now injury occurr  | ed de     | ceased was                             |          |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  OGME  29d. Date signed (Month, Day, Year) March 31, 2008  | ttendii<br>death.                    | y the n     |  |   |                  | $\frac{1}{8}$ $\frac{1}{8}$       | 2005        |            |               |                |              |             | acc            | ident        |                    |           |  |          |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  OGME  29d. Date signed (Month, Day, Year) March 31, 2008  | Divis                                | ed in b     |  | 3 Suicide                               |                  | d not be                          |             |            | ome, farm, s  | street, factor | ry, office b | uilding, et |                | or Town, S   | itate)             |           |  | ly       |
| 29b. Signature and title of certifier  The obey M. Henry My arch 29c. License number O.C.M.E.  OCME  29d. Date signed (Month, Day, Year) March 31, 2008  | Hospite                              | > -         |  | 29a. Certifier                          |                  | (0,000)                           | 1           |            | ge, death o   | ccurred at th  | ne time, da  | te and pla  |                |              |                    |           |  |          |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  OGME  29d. Date signed (Month, Day, Year) March 31, 2008  | Fo the vithin 2                      | Somple      | ֓֞֞֟֓֓֓֓֓֟֓֓֓֓֓֟֓֓֓֓֓֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | one) 2 🗸 N                              | Medical Exa      | miner: On the basis<br>and manner | of exami    |            |               |                |              |             |                |              |                    |           |  |          |
| Theoding My. Kens Myars  |                                      | N           | <b>∑</b>                               | 29b. Signature and ti                   | itle of certifie | er                                |             |            |               | 29             |              |             |                |              |                    |           | nth, Day, Year)                        |          |
|  |                                      |             |  | 1 hero                                  | lun              | M. The                            | 3           | My         | 2301          |                | U.U.N        | vi. C.      |                |              | IVIATUR 3 I,       | 2000      |  | _        |
| Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   | R                                    |             | 1                                      |   |                  |                                   | -           |            |               | 111 P          | enn Str      | eet, Ba     | iltimore, M    | D 21201      | 1                  |           |  |          |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Sign ture, Registrar APR 8 2003  |                                      |             |  |   | n, Day, Year)    | 32. F                             | Registrar's | Sign au    | ire T         | •              |              |             |                |              |                    |           |  |          |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 119 Steven Robert Bail Certificate of Death 1- For State 3 Time of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 28, 2008 0023 hrs Steven Robert Bail Me Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Catonsville Frederick Road & Oella Avenue Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number California Funeral Hours Months Days 05/26/1985 Director 22 448 98 1222 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County any 1 Yes 2 No Ellicott City or items 23a or 28a-f show must be notified at once, Howard imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
nent of Health and Mental Hygiene.
Anti: If item 27 is marked other than "natural", or items 23a or 28a-f sh 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number United States 21042 4140 Henhawk Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. 12. Was Decedent Ever in U.S. 11. Marital Status Funera White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 Yes White Specify: Yes 2 X No specify: If Yes, Give Year "natural", e 3 Widowed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ≦ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Retail the Medical Cashier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne Norton Prudhomme Thomas Edward Bail Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print ) 6235 Sandrise Court Apt 002 Elkridge, MD 21075 127 is m Rachel L. Templar Bail/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4-1-2008 Clarksville, MD Columbia Mem. Park permit. Pages
Department or
Important: J Donation 5 Other Specify 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 allis- Wit MD 21043 4112 Old Columbia Pike Ellicott City, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and ysician failure. List only one cause on each line Aedical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit hysician/Medical AMENDED tending physician are use as the burial -UNPENDED The law requires that the death certificate be-23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ć σ. 24b. Were autopsy findings available Completed Records, 24a. Was an prior to completion of cause of autopsy death? performed? certificate has be rector, page 2 sh 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital Be Residence 6 Other: Scene Other<sub>4</sub> Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 V Yes this No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury 27. Manner of Death Driver auto fixed object collision After Certification: Mar 28, 2008 0017 hrs 1 Yes 2 V No 1 Natural Pending Director: 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Frederick Rd. and Oella Ave., Catonsville, MD Could not be 3 Suicide To the Funeral D (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 28, 2008 O.C.M.E. Lastel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Redistrar's Signature 31. Date filed (Month AR State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 23, 6:05 A M MAGGIE C. BURRESS MARCH 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S FT. WASHINGTON FT. WASHINGTON REHABILITATION CENTER 8. Date of Birth (Month, Day, Year) 09-21-1914 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F NC Director 579-16-7990 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County r 28a-f show notified at 10a. State 1 X Yes 2 No Director Prince George's Suitland MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or Items 23a or Examiner must be 20746 USA 2405 Ewing Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: þ Black 3 ☐ Widowed 4 X Divorced 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Keypunch Operator 12th 2 should be filed v and Mental Hygie is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Boyd Chas Cooke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (C) s 1 and 2 of Health a item 27 is Suitland, MD 20746 2405 Ewing Avenue Georgean Twine / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Suitland, MD 03-28-2008 Lincoln Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee DONALD R. GRA 4308 Suitland Road, Suitland, MD Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final Physician Chronic Lung Disease week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 10 days Upper Gastrointestinal Bleeding Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Sacral Ulcer Stage IV 2 months signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, 1 week death certificate be G-Tube Site Infection Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 📉 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No death. I or Attencafter death Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar 29b. Signature and title of certifier

7700 Old Branch Avenue C-101 Laxmi Berwa 31. Date filed (Month, Day, Year) 32. Registrar's Signatu MAR 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

Clinton, MD

D-24535

29d. Date signed (Month, Day, Year)

03-25-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2008 7:10 P M Bacon Kerin Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Homewood of Williamsport Williamsport If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Jan. 30, Year 1920 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F 216-07-1954 88 New York Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Hagerstown MD Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 21742 12926 The Terrace Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite, any Injury or other traumatic event, the Medical Examiner ☐Yes 2X No fYes, Give ′ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite Ulrich William Carl Kerin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Allan T. Bacon II / Son 13028 Gordon Circle, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 4/9/2008 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between et and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical use as attending plant for use as IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No tal or Attending Physician: Tirs after death.

al Director: After this certificate ed in by the funeral director, pa 2 No 1⊟ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 1 Tes 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

APR 1 1 2008

Year)

29b. Signature and title



cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

29c. License number

Date signed (Month, Day, Year)

| 08- | 02469 |  |
|-----|-------|--|

Karen Renee Burroughs

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| . , , , , |            |             |         |           |        | -       |
|-----------|------------|-------------|---------|-----------|--------|---------|
| State of  | Maryland . | / Departmen | t of He | ealth and | Mental | Hygiene |

| 2008 | 1 | - 10 mm and an | 9 | and the same of | , |
|------|---|----------------|---|-----------------|---|
|------|---|----------------|---|-----------------|---|

|   |                | 1- For State<br>Registrar  |                         | •                       |              | Certific                     | ate of                     | Death                       |                    |                       |                         | Re                              | eg. No.                     |                          |                      |                             |
|---|----------------|--|-------------------------|-------------------------|--------------|------------------------------|----------------------------|-----------------------------|--------------------|-----------------------|-------------------------|---------------------------------|-----------------------------|--------------------------|----------------------|-----------------------------|
| Physicia  | in/            | 1. Decedent's Name (First, Mi  |                         |                         |              |                              |                            |                             |                    |                       | 2.                      | Date of Dea<br>Month            | th<br>Day                   | Year                     |                      | e of Death<br>10 hrs        |
| ıl Examii   |                | KAREN RENEE  |                         |                         |              |                              |                            |                             | <u> </u>           |                       |                         | Month<br>March 29,              | 2008                        | inty of Dea              |                      | TO Mrs                      |
|   |                | <ol> <li>Facility Name (if not institute)</li> <li>Doppler Street</li> </ol> |                         | reet and nui            | mber)        |                              |                            | b. City, To<br>Capitol      |                    |                       |                         |                                 | Princ                       | e Georg                  | ge's                 |                             |
| Funeral   |                | 5. Social Security Number  | 6. Sex                  |                         |              | yrs, last bi                 | rthday)                    | If Under<br>Months          | 1 Year<br>Days     | If Under<br>Hours     | 24Hrs.                  | 8. Date of Bir                  | ,                           | Fore                     | ign Was              | shington                    |
| Director  |                | 577-94-4232  | 1 M                     | 2XXF                    |              | 42                           | Yrs.                       |                             | Days               | Tiodis                | IVIIII.                 | 5/2/1                           | 965                         |                          | country) I           | DC                          |
| ž.  | F              | Usual Residence of Deceden<br>10a. State 10b. Cour                           |                         |                         | 110/         | c. City, Tow                 | n or Locatio               | on                          | -                  |                       |                         |                                 |                             |                          | 10d. li              | nside City Limits           |
| nd<br>show any<br>ice.  | _              |  | ce Geo                  | orge's                  |              | Capit                        |                            |                             | 3                  |                       |                         |                                 |                             |                          | 1 🕸                  | Yes 2 No                    |
| with the Maryland ms 23a or 28a-f show be notified at once.   | Director       | 10e. Street and Number   |                         |                         |              |                              |                            | 10f. Zip C                  |                    |                       |                         | 1                               | 0g. Citizen                 | of What Co               | ountry?              |                             |
| the N   |                | 5219 Doppler   | Stree                   | et                      |              |                              |                            | 20                          | 743                |                       |                         |                                 | United                      | l Sta                    | tes                  |                             |
| ath with the items 23a  | Funeral        | 11. Marital Status 1 XNever Married 2  | Married 1               | 2. Was Dec              |              | er in U.S.                   |                            | s Deceden                   |                    |                       |                         | cify Yes or No<br>can, etc.)    |                             | Race - Am<br>White, etc. | erican Ind           | tian, Black,                |
| P P P   | 듄              |  | Divorced If             | Yes                     | $_2$ XX      | No                           |                            | Yes 2                       | _                  |                       |                         |                                 | Sne                         | cifyB1a                  | a le                 |                             |
| ural",  | ð              | 3 Widowed 4 15. Decedent's Education (                                       | 10                      | Dates:                  |              | ted) 16a                     |                            | t's Usual O                 |                    |                       | ind of wo               | rk done                         |                             | of Busines               |                      | y                           |
| 5-0036 // led within 72 hours afte Hygiene. other than "natural", the Medical Examiner                            | Completed      | Elementary/Secondary (0-   |                         | College (1              |              |                              | during mo                  | ost of work                 | ing life. D        | O NOT U               | use retire              | d)                              | i                           |                          |                      |                             |
| 036 ithin 72 ne.  | ď              | 12   |                         |                         |              | 0                            | ffice                      | e Adm                       | _                  |                       |                         |                                 | Priv                        |                          |                      |                             |
| 5-00<br>led wit<br>Hygien<br>I other  |                | 17. Father's Name (First, Mid  |                         |                         |              |                              |                            |                             |                    |                       | ,                       | irst, Middle,                   |                             |                          | ·                    | •                           |
| 21215<br>uld be fill<br>Mental H<br>marked<br>c event, t  | o Be           | EDWARD ANDE  |                         | n Drint \               |              | 11                           | Oh Mailina                 | Address                     |                    |                       |                         | EAN BU                          |                             |                          | ate Zin C            | ode) B304                   |
| nore, MD 2121 ages I and 2 should be fi nt of Health and Mental nt: If item 27 is marked other traumatic event,   | ۲              | TOMEKA BOSTON  |                         |                         |              |                              |                            |                             |                    |                       | St I                    | NW Was                          | hingto                      | on DC                    | 2000                 | 01                          |
| re, M<br>1 and 2<br>1 Health<br>Fitem 2<br>er traum   |                | 20a. Method of Disposition  1 XBurial 2 Crema                                | tion 3                  | Removal fr              | om State     |                              |                            | ition (Name<br>ner place)   |                    |                       |                         | Date                            |                             | ation - City             |                      | State                       |
| Pages<br>lent of  |                | 4 Donation 5 Other   |                         | Removal fr              | OIII State   | Linco                        | ln Ce                      | emete:                      | ry                 |                       | 4-9-                    | 2008                            | Suit1                       | Land                     | MD                   |                             |
| Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr                              |                | 21. Signature of Funeral Serv  | ice License             |                         | 7            | •                            |                            | lame and A                  |                    |                       |                         |                                 |                             | lashi                    | ngtor                | ı DC                        |
| _ =====   |                | 23a. Part I. Enter the disease   | V /1                    |                         | ar           |                              |                            |                             |                    |                       |                         | 2617 Po                         |                             |                          |                      | 20020<br>proximate Interval |
| hysician<br>Medical   |                | failure. List only one ca  | use on each             | line.                   |              |                              | not enter tr               | ne mode o                   | dying, st          | ucii as ca            | al diac or i            | espiratory ai                   | 1631, 311000,               | or ricart                |                      | tween Onset and<br>Death    |
| Examiner  | 22 9           | Immediate Cause (Final dise<br>or condition resulting in deat                |                         | ardiac<br>e to (or as a |              |                              |                            |                             |                    |                       |                         |                                 | -                           | -                        | 3372                 |                             |
|   |                | Sequentially list conditions,  | -                       | lyocardi                |              |                              |                            |                             |                    |                       |                         |                                 |                             |                          |                      |                             |
|   | iner           | if any, leading to immediate cause. Enter Underlying Car                     |                         | e to (or as a           | consequ      | ence of):                    |                            |                             |                    |                       |                         |                                 |                             |                          |                      |                             |
| _ #   | Examine        | (Disease or injury that initiate events resulting in death) La               | d C.                    | e to (or as a           | consequ      | ence of):                    |                            |                             |                    |                       |                         |                                 |                             |                          | +                    |                             |
| 760, icate be executed physician and the burial - transit   | alE            | XUNPENDED  | d                       | AMENDED                 |              |                              |                            |                             | 1                  | /                     |                         | -                               |                             | _                        | -                    |                             |
| 760,<br>cate be exe<br>physician a  | ledical        | IF FEMALE:   |                         | 23c. If yes,            |              |                              |                            | rME,g8                      | 79 5/2             | 29/08                 | TT                      |                                 | 23d D                       | ate of deliv             | /erv                 |                             |
| 68760,<br>certificate be<br>nding physici<br>se as the buri   | ≥              | 23b. Was decedent pregnant past 12 months?                                   |                         | 1 Live t                |              | or pregnanc                  | y<br>₂∏ Fe                 | tal death                   | 3                  | Ectopic               | pregnan                 | су                              |                             | nth                      | Day                  | Year                        |
| Box 687 e death certification the attending ed for use as t   | sicia          | 1 Yes 2 No 9   | Lietanous               |                         |              | e of death                   | 5 Ot                       | ner (Spec                   | ify)               |                       |                         |                                 |                             |                          |                      |                             |
| the der   | Physiciar      | Part II. Other significant co  |                         | 9 Unkn                  |              | ut not result                | ing in the u               | underivina                  | cause div          | ven in Pa             | rt I.                   | 23e. Did                        | tobacco use                 | contribute               | to the ca            | ause of death?              |
| P.O.  | þ              | Lupus erythema   |                         | ontributing t           | o coan p     |                              |                            |                             | J                  |                       |                         | 1Y                              | es 2 🗸 N                    | о з г                    | Probably             | 4 Unknown                   |
| ords, P.C. w requires that us been signed by should be deta   | Completed      |  |                         |                         |              |                              |                            |                             |                    |                       |                         | 24a. Wa                         |                             |                          |                      | findings available          |
| COF<br>law r<br>e has b<br>e 2 sh   | )du            | l'   |                         |                         |              |                              |                            |                             |                    |                       |                         | perf                            | opsy<br>formed?             | death                    | 1?                   | 2 No                        |
| of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should b |                | 25. Was case referred to me  | tical                   |                         |              |                              |                            | 2                           | 6.Place o          | of Death              | (Check or               |                                 | 2No                         | 1 🗸                      | res                  | 2 10                        |
| Vital<br>ysician<br>his cert<br>directo   | Be             | examiner?  |                         | spital:                 | Inpatient    | 2 ER                         | /Outpatient                |                             |                    | Other 4               |                         | Home 5                          | Residence                   | 6 <b>V</b> O             | ther: Scer           | ne                          |
| of \ing Phy After th uneral   | ): To          | 27. Manner of Death  |                         | 28a. Date               | of Injury    |                              | b. Time of I               | Injury 2                    | 8c. Injury         | at Work               | ?                       | 28d. Describe                   | how injury                  | occurred                 |                      |                             |
| on<br>tendin<br>eath.<br>or: A  | ation          |  | Pending<br>nvestigation | '                       | ii, Day, roa | '                            |                            |                             | 1 Ye               | es 2                  | No                      |                                 |                             |                          |                      |                             |
| Division fal or Attendii rs after death. al Director:   | itic           | 3 Suicide 6  | Could not be            | 28e Plac                | ce of Injur  | y - At home                  | , farm, stre               | et, factory,                | office bu          | ilding, et            | c.                      | 28f. Location or Town,          |                             | Number of                | Rural Ro             | oute Number, City           |
| in spi  | Certification: | 4 Homicide   | etermined               | (Specify)               |              |                              |                            |                             |                    |                       |                         |                                 |                             |                          |                      |                             |
| ple ii h  | Medical        | 29a. Certifier 1 Certifyin one) 2 Medical                                    | Examiner: C             | n the basis             | of examir    | nowledge, on<br>nation and/o | death occu<br>ir investiga | rred at the<br>ition, in my | time, dat opinion, | e and pla<br>death oc | ace, and o<br>curred at | due to the car<br>the time, dat | use(s) and n<br>e and place | nanner as<br>, and due t | stated.<br>o the cau | se(s)                       |
| To To Corr  | Mec            | 29b. Signature and title of ce   |                         | nd manner :             | stated       |                              |                            | 29c                         | . License          | number                |                         |                                 | 29d. Dat                    | te signed                | (Month, D            | Day, Year)                  |
|   |                | Mouhre   | Me                      | 46.1                    |              |                              |                            |                             | O.C.N              | 1.E.                  |                         |                                 | March                       | 30, 200                  | 08                   |                             |
| ,   | 1 4            | 30. Name and address of pe   | son who coi             | mpleted cau             | use of dea   | th (Item 23a                 |                            |                             |                    |                       |                         |                                 |                             |                          |                      |                             |
| _   | A 11           | Margarita Korell M   |                         | istant Me               | edical E     | xaminer                      | 111 P                      | enn Str                     | eet, Ba            | Itimore               | e, MD 2                 | 1201                            |                             |                          |                      |                             |
| Si<br>Regis   | tate<br>trar   | 31. Date filed (Month, Day Y   | 800                     | 32. R                   | egistrar's   | Signature                    | de                         |                             |                    |                       |                         |                                 |                             |                          |                      |                             |
|   |                |  |                         |                         |              |                              |                            |                             |                    |                       |                         | _                               | _                           |                          | G                    | CME                         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death March 20Day **Physician** R. Cassell James 200<sup>Y</sup>8ª 8:20 ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George If Under 1 Year If Under 24 Hrs. Nov 24, 1957 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 7. Age (In yrs, last birthdav) **Funeral** 1XM 2□F 50 228-88-6643 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits ms 23a or 28a-f show must be notified at 1 ☐X es 2 ☐ No Lothian Md Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 441 Sarah Anne Drive USA Funeral 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner filed within 72 hours after 1X Never Married 2 ☐ Married 1 X Yes 2 No if Yes, Give Year or Dates: ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Black Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Bus Operator 12th i and Mental Hygic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Lawrence Thompson Dorothy Mae Cassell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Rosa Walker Martin (Aunt) 6519 Halleck St. District Hghts Md.20747 20b. Place of Disposition (Name of Oak Grove Baptist 03/31/08 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lawrenceville Va. 4 Donation 5 Other (Specify) Church Cemetery 21. Signat of Funeral rvice Lic 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part. Inter the dis shock or heart failu immedine Cause (Final disease or condition resulting in death) nt. Inter the disease ons that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between Onset and Death Sephiemo Physician /Medical Due to (or a a consequence of): Examiner ract Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical with ending pure IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for u 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 I Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C 29a. Certifier 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 03/20/2008

State

31. Date filed (Month, Day, Year) MAR 2 7 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SITRI

DHMH 17 Rev 1/2001

Registrar

7503

RD,

SURRATIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23d. Date of delivery

Year

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Month

**Physician** /Medical Examiner

Department of Health Important: If item 27 any injury or other troonce.

show

death

Pages 1 and 2 should be filed within 72 hours after

John Frederic Cleaveland

19a. Informant's Name/Relationship (Type. Print)

altimore, Maryland 21215-0036

use as the burial-trai physician attending p been signed by the should be detached cate has page 2 s ertificate director. this uneral ours after death.

neral Director; Af

filled in by the fu

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records.

the Hospital or Attending Physician;

To the Hospital within 24 hours a To the Funeral I

6

completely

Physician/Medical Examiner

Be

Certification: To

Medical

State

Registrar

Robert B.

31. Date filed (Month.

7421 Quaker Neck Rd., Bozman, Md.21612 Carol Stewart (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Capitol Crematory 3-25, 2008 Dover, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 2/2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2[] No W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie かえかつしひ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200k

32. Registrar's Signature

Sanchez

DHMH 17 Rev 1/2001

508 Idlewilde Ave. Easton, Md.

DHMH 17 Rev 1/2001

Registrar

1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

| Physicia<br>/Medica<br>Examine  |                     | For<br>State<br>Registrar   | State of Maryla   |                                   |   |  | Wichitah                 | rygierie                      | 2000                                    | 1101   |
|---|---------------------|---|---|-----------------------------------|---|--|--------------------------|-------------------------------|---|--|
| /Medica   |                     |   |   | UE1                               | tificate o  | r Death  |                          | Reg. No                       | ~~~~~                                   | 1191   |
| /Medica   |                     | <ol> <li>Decedent's Name (First, Middle, Last)</li> </ol>   |   |                                   |   |  | 2. Date of               | Death                         |   | 3. Time of Death                               |
| Examine   |                     | William W C   | mu ford   |                                   |   |  | Month 3                  | S C                           | Year 08                                 | 11:54 A  |
|   | er                  | 4a. Facility Name (If not institution, give   | street and number)  |                                   | 4b. City, Town  | n, or Location of De                             | ath                      | 40                            | . County of Death                       |  |
|   |                     | 5. Social Security Number 6. Sec  | edia (12+1  | ( )                               | If Under 1'Ye   | ar If Under 24 H                                 |                          |                               |   | inde /   |
| Funeral<br>Director   |                     | -   | 2 F 7. Age (in yrs  | . last birthday)<br>Yrs.          | Months Day  |  |                          | Day, Year,                    | Cou                                     | place (State or Fore                           |
|   | -                   | Usuel Residence of Decedent   |   |                                   |   |  | reb /                    | , 193                         | ) wasn                                  | ington, D                                      |
| whow<br>Talk  | . 1                 | 10a. State 10b. County  | 10c. C  | city, Town or Lo                  | cation  |  |                          |                               |   | 10d. Inside City Lim                           |
| 28a-f   | ecto                | Maryland   Prince Go  | eorge's   | Bowie                             | 1   |  |                          | 1                             |   | 1 ਊ Yes 2 ☐ I                                  |
| To a  | ۵                   | 3111 Aventine Lar   |   |                                   | 10f. Zip Cod  |  |                          |                               | tizen of What Cou                       | ,  |
| tran "natural", or items 23a or 28a-f show<br>the Medical Examinar must be notified at        | by Funeral Director | · · · · · · · · · · · · · · · · · · ·   | 12. Was Decedent Ever in  | U.S. 13. V                        | 207.  | L O<br>of Hispanic Drigin?<br>uban, Mexican, Pue | Specify Yes or           |                               | nited St<br>14. Race - Amer             |  |
| e a   | בֿ<br>ב             | 1 Never Married 2 Married   | Armed Forces?<br>1 (X)Yes 2 □ No<br>If Yes, Give                                  | 1                                 |   |  | nto Rican, etc.)         |                               | Black, White                            | , etc.   |
| E   | g p                 | 3 ☐ Widowed 4 ☑ Divorced  | Year or Dates:  |                                   | 1 ☐ Yes 2 💢 1   | No Specify:                                      |                          |                               | Specify:                                | 1ack   |
| nation  | Completed           | 15. Decedent's Edu<br>(Specify only highest grade   | cation<br>e completed)  | (Give                             | ient's Usual Do<br>kind of work do:<br>DO NOT use ret | ne during most of w                              | orking                   | 16b. K                        | (ind of Business/fi                     | ndustry  |
| than  | E O                 | Elementary/Secondary (0-12) 12 years  | College (1-4or 5+)  |                                   | Chef  | 1160)  |                          |                               | Destructo                               |  |
| 2 E H   | Bec                 | 17. Father's Name (First, Middle, Last)   |   |                                   | JIIET   | 18. Mother's N                                   | ame (First, Mide         |                               | Private<br>Sumame)                      |  |
| arked c   | 9                   | Mayo Crawford,  | Sr.   |                                   |   | Ella I   | Mae Bra                  | nch                           |   |  |
| 3 2 2   |                     | 19a. Informant's Name/Relationship (Ty  | * *   |                                   |   | et and Number or I                               |                          |                               |   | p Code)  |
| item 27<br>other tra  | -                   | Marcia G. Spriggs   |   |                                   |   | ne Lane B  |                          | _                             |   |  |
| 5 = 2   |                     | 20a. Method of Disposition<br>1   Burial 2 ☐ Cremation 3 ☐ R  | emoval from State   | Place of Dispo-<br>cemetery, cren | natory or other p                                     | olace)   | Date                     |                               | ocation - City or T                     |  |
| ortant:<br>injury   |                     | 4 ☐ Donation 5 ☐ Other (Specify)  21. Significant Funeral Server Lions                                      |   | surrect                           | ion Cer   | netery Ma  | r 28, 20                 | 800                           | Clinton,                                | MD   |
| important: i<br>eny injury o  |                     | 21. Signification Policies Server Library   | Harriot   |                                   |   | dress of Facility                                |                          |                               |   |  |
|   | $\dashv$            | 23a. Part1. Egter the disease, or compli  | cations that caused the dea   |                                   |   |  |                          |                               | gron, Do                                | Approximate                                    |
| sician  |                     | Immediate Cause (Final  | ne cause on each line.  |                                   | 2   |  |                          |                               |   | Interval Between<br>Driset and Death           |
| ledical   |                     | disease or condition resulting in death)  | Due to (or as a conse   | quence of):                       | art Di  | SPGJE  |                          |                               |   |  |
| aminer  |                     | Sequentially list conditions  | Consestive  | Hear                              | + Fa,   | lure   |                          |                               |   |  |
| sit L   | Iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse   | quence of):                       |   |  |                          |                               |   |  |
| ial-transit   | хаш                 | that initiated events resulting in death) Last  | Due to (or as a conse   | uneuce ot).                       |   |  |                          |                               |   | 20 minuse                                      |
|   | Cal                 |   |   | quarica orj.                      |   |  |                          |                               |   |  |
| as the  |                     |   |   |                                   |   |  |                          |                               |   |  |
| attending phy   |                     | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome of pregr  |                                   | le . A.T. A.T. Cook                                   |  |                          |                               | 23d. Date of deliv                      | ery  |
| detached for  | SICIB               | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1 Live birth 2 Fet<br>4 Pregnant at time of<br>9 Unknown                          |                                   | Ectopic pregna:<br>Other (specify)                    |  |                          | _                             | Month                                   | Day Year                                       |
| d by the  | ٦                   | 9 Unknown   |   | -0.1                              |   |  |                          |                               |   |  |
| be o  | <u>`</u>            | Part II. Other significant conditions con   | Inbuting to death but not re  | sulting in the ur                 | iderlying cause                                       | given in Part I.                                 |                          |                               |   | the cause of death?                            |
| hould   | etec                | il ray land   | ·   VIJ(5) &  |                                   |   |  |                          | Yes 2                         | □No 3□Pro                               | bably 4 Strikno                                |
| page 2 should   | Ē.                  | Hypertenjive H  | cont 1111916  |                                   |   |  |                          | tas an<br>itopsy<br>informed? | 24b. Were auto<br>prior to co<br>death? | opsy findings availal<br>empletion of cause of |
| certificete has<br>rector, page 2   |                     | 25. Was case referred to medical  |   |                                   |   |  | 1 ☐ Ye                   | s 2,23.No                     |   | 2 No   |
|   | מ                   | examiner?   | ospital: Inpatient 2  | ER/Dutpatient                     | 3 DOA   | Thos   | Home 5 P                 |                               | 6 ☐Other (Speci                         | A.)  |
| £ =   |                     | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury               | 28c. In   |  | 28d. Describ             |                               |   | у)   |
| be fur  | Sation              | 1 Natural 5 Pending 2 Accident investigation  | (mona, bay roa)   | ,,,,diy                           |   | ☐Yes 2☐No  |                          |                               |   |  |
| al Director: After led in by the funera   |                     | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h<br>building, etc. (Spec                               | nome, farm, stre                  | et, factory, offic                                    | æ  | 28f. Location<br>City or | n (Street ar<br>Town, State   | nd Number or Run                        | al Route Number,                               |
| ie ie c   | 2                   | 00 0 15   |   |                                   |   |  |                          |                               |   |  |
| To the Funeral Director: After the completely filled in by the funeral Madical Certification: | Can                 | 29a. Certifier  (Check only one)  2 Medical Examir  | sician: To the best of my kn<br>ter: On the basis of examin<br>and manner stated. | ation and/or inv                  | estigation, in m                                      | time, data and plan<br>y opinion, death occ      | e, and due to the time   | lie sausa(s<br>ie, date ani   | ) and manner as a<br>d place, and due t | tated.<br>o the cause(s)                       |
| to the Funeral Director: After completely filled in by the funer Medical Certification.       |                     | 29b. Signature and title of certifier   | and manner stated.  |                                   | 29c. Lice   | nse number                                       |                          | 29d. Da                       | te signed (Month,                       | Day, Year)                                     |
|   |                     | ▶ M. N  | MD  |                                   | Do  | 4089   |                          | 1                             |   | *  |
| 6)  | -                   | 30. Name and address of person who co   |   | m 23a) (Type. i                   |   | ^  | - In                     | )                             | 10 1/20                                 | -0   |
| 0/  |                     | Mark Sarcher  | MD 30   | 00 /M                             | Miss  | 1089<br>Park y                                   | A.                       | no li                         | MO                                      | 21224  |
|   |                     | 31. Date filed (Month, Day, Year)   | a 32. Registrar's Sign  | atura.                            |   | 1  |                          | 7                             |   | 4-   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Jean Councill Chase MARCH 28 2008 9:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deve Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 V F 212-22-0168 7/27/1921 MD Director 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must b 9004 West Biscayne Dr. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No CHASE JEAN Baltimore, Maryland 21215-0036 Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilford Councill Theresa Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas C. Chase, Jr. 9004 West Biscayne Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Cemetery 4/2/2008 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final ardibrascula **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown sate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No After this certificate has director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 L Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital
within 24 hours a
To the Funeral C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation in my paining death occurred at the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

BA 3

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)



no completed cause of death (Item 23a) (Type, Print)

Fewert Foland, De 19944

LINCOLN MEMORIAL CEM. 03/29/2008

20b. Place of Disposition (Name of cemetery, crematory or other place)

18. Mother's Name (First, Middle, Maiden Surname) BOOKER

1 CAMERON GROVE BLVD.#103, UPPER MARLBORO, MD 20774

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

SUITLAND, MARYLAND

Approximate Interval Between Onset and Death

days

ALICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

Date

filed within 72 hours after death with the Maryland Hygiene. a or 28a-f show t be notified at "natural", or Items 23a Baltimore, Maryland 21215-0036 other permit. Page Department o Important: If any Injury or once,

**Physician** 

/Medical

**Examiner** 

10a State

Directo

Funeral

Š

Completed

MD

HERBERT

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

TIBBS

19a. Informant's Name/Relationship (Type. Print)

CHARLOTTE COLLINS/ DAUGHTER

1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**Funeral** 

Director

**Physician** /Medical Examiner

22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 716 KENNEDY ST. NW, WASHINGTON, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate outer. Enter the John of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed Pailure Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760

within 24 ho

To the Function

State Registrar

31. Date filed (Month, Day, Year) MAR 2 7 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

State Registrar 31. Date filed (Month, Day, Year)

Elocran

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



REISTENSTOWN

May Coenric

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

State

Registrar

filed (Month, Day,

Yea()

1 2008

32. Registrar's Signature

MAR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4 **Physician** 3 2008 2:37 P M Selina Donahue /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 118 Pinetree Rd. Ocean City Worcester If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 23, 1930 5. Social Security Number 6 Sex Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 ☑ F 77 Pennsylvania 218-26-4848 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 118 Pine Tree Road 21842 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Plastic Mfg. Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ewalt Louis Killmer Edna Isabelle Drew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 118 Pine Tree Rd., Ocean City, MD 21842 William N. Donahue, Jr., Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 8, 1 N Burial 2 □ Cremation 3 N Removal from State New Freedom Cemetery 2008 New Freedom, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. I run val Service Lice s, e -24 Second St., New Freedom, PA 17349 ar Que 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BRIGAST **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an certificate 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A filled in by the fu death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27993 4-4-08 an

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

ocean (it mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Philadelphia

32 Registrar's Signature

Die

# VOID

## CERTIFICATE #

2008-11923

SEE

CERTIFICATE #

2008-12050

|  |  | Certificate of Death   | Reg. No. 2008  | 1192   |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician  | Decedant's Nama (First, Middla, Last)  |  | 2. Data of Daath<br>Month Day Yaar                             | 3. Time of Death   |  |  |  |  |  |  |  |
| /Medical   |  | guson  | March 20, 2008   | (9:30 pm   |  |  |  |  |  |  |  |
| Examiner   | 4a Facility Name (If not institution, giva street and number   |  | or Location of Daath 4c. County of Daat                        | h  |  |  |  |  |  |  |  |
|  | Gladys Spellman Nursing  |  | sville Prince C  |  |  |  |  |  |  |  |  |
| Funeral Director   | 5. Social Sacurity Numbar 6. Sax 7. A 1  | ga (In yrs. last birthday) If Under 1 Yaar If Under 24  4 8 Yrs. Months Days Hours I         | Vin. (Month, Day, Yaar) Co                                     | hplaca <i>(State or Foreig</i><br>untry)<br>uisi <b>an</b> a |  |  |  |  |  |  |  |
| p .  | Usual Rasidence of Dacedant  10a. Stata 10b. County  | 10.00 -  |  |  |  |  |  |  |  |  |  |
| ehow   | 10a. Stata 10b. County   | 10c. City, Town or Location  |  | 10d. Insida City Limit<br>1⊠ Yas 2 □ N                       |  |  |  |  |  |  |  |
| the Man<br>28a-f eh<br>notified<br>rector  | Md. Montgomery   | Silver Spring  |  |  |  |  |  |  |  |  |  |
| uffer death with the Ma r frems 23a or 28a-fe niver must be notified Funeral Director  | 10e. Street and Numbar 2397 Jones Lane   | 10f. Zip Coda 20902  | 10g. Citizen of What Co  | untry?   |  |  |  |  |  |  |  |
| dea dea  | 11. Marital Status 12. Was Dacadant Armed Forcas   | Evar in U,S. 13. Was Decadant of Hispanic Origin If Yas, specify Cuban, Maxican, P           | ? (Spacify Yas or No-  |  |  |  |  |  |  |  |  |
| . 0 3  | 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ If Yas, Giva Yaar or Datas:  | No   | uarto Rican, atc.)  Black, White Specify: B1                   |  |  |  |  |  |  |  |  |
| led within 72 ho<br>bygiene.<br>Ner than "nature<br>it, the Medical I  | 15. Decedant's Education   | 16a. Decedent's Usual Occupation   | 16b. Kind of Business/   | Industry   |  |  |  |  |  |  |  |
| pie pie  | (Spacify only highast grada complated)  Elamantary/Secondary (0-12) Collega (1-4or                                 | (Give kind of work done during most of life. DO NOT usa retired)                             | working  | _  |  |  |  |  |  |  |  |
| Page P   | 12th   | Housewife  | Self-Empl  | .oyed  |  |  |  |  |  |  |  |
| be file<br>tel Hyg<br>d othe<br>event,<br>Be C   | 17. Fathar's Name (First, Middla, Last)  | 18. Mother's   | Name (First, Middla, Maidan Sumama)                            |  |  |  |  |  |  |  |  |
| Mante Marked artic ev  | Charles Norris   | Melv   | a Jones  |  |  |  |  |  |  |  |  |
| 12 shou<br>hend M<br>hend M<br>rement  | 19a. Informant's Nama/Ralationship (Type, Print) Lloyd A. Ferguson (Hus)   |  | r Rural Route Number, City or Town, Stata, 2                   |  |  |  |  |  |  |  |  |
| end<br>leatth  |  |  | Silver Spring, Md. 20  |  |  |  |  |  |  |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours Depetment of Heath and Mantel Hygiene. Important: if hem 27 ie marked other than "neturel", any injury or other traumatic event, tra Madical Exponse.  To Be Completed by  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)       | 20b. Place of Disposition (Name of cemetery, cramatory or other place) Harmony Memorial Park | Data 20c. Location - City or 03-28-2008 J.andove               |  |  |  |  |  |  |  |  |
| ertm<br>e int.   | 21. Signature of Funeral Service Licensee  | 22. Nama and Address of Facility   | . 1  |  |  |  |  |  |  |  |  |
| Depe<br>Impo   | Wanda C. Bacon   | W. H. Bacon Fun<br>2. CC36/ 3447 14th Street   | , N.W. Washington, D   | .c. 20010  |  |  |  |  |  |  |  |
|  | 23a. Part1. Entar tha diseasa, or complications that causa shock, or heart failure. List only ona cause on each li | tha daath. Do not enter the mode of dying, such as car<br>ne.                                | diac or raspiratory arrast,                                    | Approximate<br>Interval Between                              |  |  |  |  |  |  |  |
| Physician<br>/Medical  | Immediate Causa (Final Sept:   | ic Shock   |  | Onset and Death  |  |  |  |  |  |  |  |
| Examiner   | disease or condition resulting in death)  Due to (or as a consequence of):   |  |  |  |  |  |  |  |  |  |  |
| je la la la la la la la la la la la la la  | Aspiration Pneumonia   |  |  |  |  |  |  |  |  |  |  |
| antificate be executed ing physician and a es the bunal-transit Medical Examiner   | D  | Due to (or as a consaquence of):   |  |  |  |  |  |  |  |  |  |
| Exa  | Sequantially list conditions, if any, laading to immediate cause. Entar Undartying Causa (Disaasa or injury        |  |  |  |  |  |  |  |  |  |  |
| physician<br>se the burn<br>edical I   | Causa (Diseasa or injury that initiated avants resulting in death) Last  Due to (or as a consequence of):          |  |  |  |  |  |  |  |  |  |  |
| edi edi  | rasulting in death) Last   | Dua to (or as a consaquence or).   |  |  |  |  |  |  |  |  |  |
| in that the attending the date of the attending additional that is detected for use a year year year year year year and the attent and the attent attent and the attent attent attent and the attent a | d  |  |  |  |  |  |  |  |  |  |  |
| atta<br>1 for<br>Icia  | Port II. Other classificant and date according to the death to   |  |  |  |  |  |  |  |  |  |  |
| d by the attand ateched for us   | Part II. Other significant conditions contributing to death b  | ut not rasulting in tha undariying causa givan in Part I.                                    | 23b. Did tobacco usa contributa                                |  |  |  |  |  |  |  |  |
| date date  | Anoxic Encephalopathy  |  | 1 ☐ Yes 21⁄X No 3 ☐ Pr   | obably 4 Unkno   |  |  |  |  |  |  |  |
| 2 5 5 <b>2</b>   |  |  | 24a. Was an autopsy 24b. \                                     | Were autopsy findings  |  |  |  |  |  |  |  |
| that law raquity that has been so pege 2 should Completed  |  |  | parformad?   | vailable prior to<br>completion of cause                     |  |  |  |  |  |  |  |
| has<br>be 2 :  |  | -  |  | of death?  |  |  |  |  |  |  |  |
|  |  |  | 1 □ Yes 2₺No 1   | ☐ Yes 2월 No  |  |  |  |  |  |  |  |
| cartificate ractor, peg  | 25. Was case referred to medical examiner?   | 26. Place of   | Death (Check only one)   |  |  |  |  |  |  |  |  |
| this cartific<br>ral diractor,<br>TO Be  |  | ent 2 ER/Outpatient 3 DOA Othar: Nursin  | ng Homa 5□ Rasidance 6 □Other (Spec                            | cify)  |  |  |  |  |  |  |  |
| or Attending Printer death.  Director: After thing in by the funeral ertification:   | 27. Mannar of Death 1 Natural 5 Panding 2 Accidant invastigation  28a. Data of Inju (Month, Da                     |  | 28d. Dascribe how injury occurred                              |  |  |  |  |  |  |  |  |
| lal or Attending P<br>is aftar death.<br>In Director: After ted<br>in by the funera<br>Certification:  | 2 Could not be   | ury - At home, farm, streat, factory, offica   | 28f. Location (Streat and Number or Ru<br>City or Town, State) | ral Route Number,  |  |  |  |  |  |  |  |
| Funeral D<br>Funeral D<br>Staly filled in  | 29a. Certifier 1⊠ Certifying Physician: To the best  | of my knowledge, death occurred at the time, date and pl                                     | ace, and due to the cause(s) and manner as                     | stated   |  |  |  |  |  |  |  |
| within 24 hours after the within 24 hours after the Completally filled in by the Medical Certific  | (Check only 2 Medical Examiner: On the basis of and manner sta   | examination and/or investigation, in my opinion, death o                                     | ccurred at the time, date and place, and due                   | to the cause(s)  |  |  |  |  |  |  |  |
| vithin 2<br>To the<br>comple   | 29b. Signature and title of certifier  | 29c. License number  | 29d. Date signed (Month  |  |  |  |  |  |  |  |  |
|  | The Miller   | D0026024   | March 21   | , 2008   |  |  |  |  |  |  |  |
| $\widehat{2}$  | 30. Name and addrass of person who completed cause of d  |  | iite 106 Washington,   | DC 20017   |  |  |  |  |  |  |  |
|  | Lester Miles, M.D.   |  | TEC IOO Washington,  | 2001/  |  |  |  |  |  |  |  |
| State<br>Registrar   | MAR 2 7 2008   | ar's Signatura   |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 23a-b per phy aaco hlth dept 03/27/08 dlw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Andrew 3/22/2008 12:40pm<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death Examiner 130 Glen Rd. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5/25/1919 Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. XXM 2□ F 88 216-05-8661 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 Glen RD. 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ★★Yes 2 No If Yes, Give Year or Dates: 1 Never Married 213 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXNo White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew J. Gill Mae T. Hanrahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Gill Wife 130 Glen Rd. Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Metro Crematory 3/26/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Gervice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the distrase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 LYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 PAesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated nd title oertifie 29d. Date signed (Month, Day, Year)

Karl Kasamon, M.D. 31. Date filed (Month, Day, Year) State Registrar

10840 Little Patuxent Pkwy Suite 300 32. Rajistrar's Signature MAR 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Columbia, MD 21044

| 08-0256 | 6  |       |
|---------|----|-------|
| Gregory | L. | Gantt |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 1. Decedent's Name (First, Middle,Last)  GREGORY L. GANTT  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County  4c. Death  4c. County  4c. Death  4c. County  4d. Dunders dark  4d. Dunders dark  4d. Du |   |          | - For State eqistrar Certificate of   | Health and Mental Hygiene Death Reg. No. 2008  | 92        |  |
|--|---|----------|---|--|-----------|--|
| Secretary Death   April   Prince George   Secretary   Prince George   Pr   |   | in/      | I. Decedent's Name (First, Middle,Last)   | Month Day Year 0029 bro  |           |  |
| The company of the control of the c  |   |          | 4a. Facility Name (if not institution, give street and number)  | b. City, Town, or Location of Death  4c. County of Death                               |           |  |
| Use memorine of Detection    Courties   Detection   De |   |          |   | Months Days Hours Min. MAY 12 1954 SOUTH CAROL   |           |  |
| MID PRINCE GEORGE'S BOWIE    No. Street and hurboar  | 8   |          | Usual Residence of Decedent   |  | imite     |  |
| 4 620 MORNING CLORY TRAIL.    Marcal States   Language  | <u> </u>  |          |   |  |           |  |
| American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department of the Control of Section 1   American Department   | he Marylan<br>1 or 28a-f sl<br>iffed at onc   |          | 10e. Street and Number  |  |           |  |
| 20s. Memory of Disposition   Specific   Spec | death with t  |          | 1 Never Married 2 Married Armed Forces?   |  |           |  |
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| 20a. Member of Disposition (Name of Ceremetry)  1   Name and Address of Facility  1   Name and Address of Facility  2   Separation of Disposition (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Ceremetry (Name of Ceremetry)  2   Separation of Cereme | 136<br>hin 72 hour<br>e.<br>than "natu  | pleted   | Elementary/Secondary (0-12) College (1-4 or 5+)   | ost of working life. DO NOT use retired)   |           |  |
| 20. Method of Daposition (Name of Cereteley)  21.   Mayoria   2   Ceremation   3   Removal from State   20. Detection City of 1 lown, State   20.  | MD 21215-00<br>3.2 should be filed wit<br>th and Mental Hygien<br>1.27 is marked other<br>umatic event, the M |          | 3 110   | 18.Mother's Name (First, Middle, Maiden Surname)                                       |           |  |
| 20. Method of Daposition (Name of Cereteley)  21.   Mayoria   2   Ceremation   3   Removal from State   20. Detection City of 1 lown, State   20.  |   |          |   |  |           |  |
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| Section   Part   Enter the despéd, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only oper Gause on each line.   Part   Enter the despéd, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only oper Gause on each line.   Part   Enter the despéd, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or the discussion of the complete of the deeth.   Part   P   | ore,<br>es l and<br>of Heal<br>If iten  |          | 1 XBurial 2 Cremation 3 Removal from State crematory or   | ner place)   |           |  |
| 236 Part   Enter the datespéd, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope Cause on each time immediate Cause (Final disease or condition resulting in death)  | it. Pag<br>rtment<br>ortant:  |          | 4 Donation 5 Other Specify.   |  |           |  |
| Sequencially list conditions    | Depart Depart Injury  |          | K.D. N-hall   | 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785  |           |  |
| Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Final United Hyping Cause (Disease or injury that initiated Course in each)  Late of or as a consequence of):  Due to (or as a consequence of):  Du | /Medical  |          | failure. List only one cause on each line.  | Between Onse   |           |  |
| The course of the second program of the seco |   |          | Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease  |  |           |  |
| With the past 12 months of the past 12 month |   | <u>ا</u> |   |  |           |  |
| The color of the   | _   | in in    | Cause. Emer Underlying Cause (Disease or injury that initiated  |  |           |  |
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| The property of the past 12 months?    The property of the past 12 months?   1   | ਤ ਜ਼ੁਲ  | dica     | #20a,PII,2/,pen/E,g8/9  | /23/08 TT  |           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part II. Other significant conditions   Part II.   Part I | 6876<br>certificat<br>nding ph  |          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5                    | atal death 3 Ectopic pregnancy 23d. Date of delivery  Month Day Yes                    | ar        |  |
| Epilepsy    Type   2   No 3   Probably   4   Unknown   24a. Was an autopsy findings available prior to completion of cause of death?   1   Yes 2   No   1   Yes | the deal  | Phys     | 9 JOHNIOWII   | underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deal | th?       |  |
| 25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1  | P.C. es that signed to be deta  | by       |   |  | nown      |  |
| 25. Was case referred to medical examiner?  1  | OrdS<br>nw requir<br>as been<br>2 should  | plete    |   | autopsy prior to completion of cau   |           |  |
| Solicide   Accident   Suicid   | Kec<br>The la   | Com      |   | 1 Yes 2 No 1 Yes 2   | No        |  |
| Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number O.C.M.E.  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year)  April 1, 2008  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  | /ital<br>sician:<br>iis certi   | m        | examiner? [Hospital: 4   Invational 2   ED/Outpaties  | 104-11   |           |  |
| Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)  2 Accident 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Or Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier O.C.M.E. OCME April 1, 2008  30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   |   |          | 27. Manner of Death  28a. Date of Injury  (Month Day Year)  28b. Time of Month Day Year)  |  |           |  |
| Secretifier   Check only   Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   Check only   Ch   | SION<br>strendi<br>death.<br>ctor: /  | atio     | A Natural 5 Pending Investigation   |  | 0:4:      |  |
| Secretifier   Check only   Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   Check only   Ch   | DIVIS<br>tal or A<br>rs after<br>al Dire  | ertifi   | Suicide Could not be determined (Specific)  |  | er, City  |  |
| DC    Sold   Complete and title of certains   Document  | e Hospi<br>n 24 hou<br>e Funer<br>etely fil   |          | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |           |  |
| O.C.M.E. OCME April 1, 2008  30. Name and address of person who completed caute of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  | To th<br>within<br>To the   | Medic    | and manner stated.  |  |           |  |
| Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   |   | _        | Last Signature and the or continue  | OCAAF  |           |  |
| Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   | De  |          | 30. Name and address of person who completed cause of death (Item 23a)  |  |           |  |
|  |   |          |   | 111 Penn Street, Baltimore, MD 21201   |           |  |

ORIGINAL

Division or Vital Records, P.O. Box 68760

State Registrar DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 319 31. Date filed (Month, Day, Registrar's Signature Year) 2008

and manner stated.

**ORIGINAL** 

29c. License number

ashington

29d. Date signed (Month, Day, Year) 3121108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 2008 **Physician** 12:15 AM Mar WILLIAM E. HARRIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare - The Pines Easton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
OCT 12,1927 Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Min 1X M 2 □ F 80 NC Director 216-22-4575 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Yes 2 □ No Director EASTON TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 610 DUTCHMANS LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ 4 es 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Harris Maryland 21215-0036 Specify: δ WHITE 3 ☐ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CIVIL SERVICE FIREMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harri MARY SUE FITCHETT WILLIE ELBERT HARRIS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH PINSKY SCHMICK/SISTER 7823 WOODLAND CIRCLE, EASTON, MARYLAND 21601 Baltimore, William 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State MD VETERANS CEMETERY 3/28/2008 HURLOCK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERON 200 S. HARRISON ST EASTON, MD 21601 JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 000 /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 No Yes To the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Funeral 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 21804 ROBINS 200 Civic F 31. Date filed (Month, Day, State 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Hayder М man 2 3008 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1M5 NA Baltimo If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Director 40 212 76 0136 July 11, 1967 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 6151 Camelback Lane 21045 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes ZX No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 🏖 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than '9 any injury or other traumatic event, the Me any injury or other traumatic event, the Me onee. Elementary/Secondary (0-12) College (1-4or 5+) Manager Barnes & Noble 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Thomas Hayden Erin Flanagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erin F. Hayden/Mother 6151 Camelback Lane Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Ardent Crematory 3-28-2008 | Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dermato muo siti **Physician** month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 24 and manner stated. the within 7

State Registrar

Year) MAR 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

olleen



Green

29c. License number

54

: 18212 066 73

Baltimore

29d. Date signed (Month, Day, Year)

MO 21230

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/25/2008 2210 Somona W. Howard 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Arbor at Bay Woods Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 3irthpic. Country) CT 7. Age (In yrs. last birthday, Months Hours Days Min (M°7" 8" 1916 1 □ M 2KCKF 91 137-22-7964 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 FxNo MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bayfront Dr. 21403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK Weinberger Lena Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Granddaughter Joanna Breen 222 Riverside Dr. New York, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Teresa's Cemetery 3/29/2008 4 □ Donation 5 □ Other (Specify) Summit, NJ 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fyneral Service License Jaka 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PIMER disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and deed detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforn To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 🗌 Yes 2 ∏No after death. 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifie 0029571 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) fense Hwy, crofton, MD 21114 B. Barez 2225 aV1 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 24, 4:20 A M 2008 March Jacque W. Hopkins /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Prince George's Community Hospital Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 12-12-1926 9. Birthplace (State or Foreign 5. Social Security Number 577–30–1054 6 Sex **Funeral** 1 X M 2 □ F Ritchie, MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "national" any injury or other transitions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No MD Prince George's Cheverly Director 10f. Zip Code 20785 10g. Citizen of What Country? 10e. Street and Number United States 6114 Arbor Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1945-1 Never Married 2K Married Specify: White 1 ☐ Yes 2 🛛 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1948 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Beall (unknown ) Hopkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6114 Arbor Street Cheverly, MD 20785 Alice P. Hopkins ( wife ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/28/2008 Brentwood, MD Fort Lincoln Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, MD 20722 Road Bladensburg 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between I month Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Physician /Medical Due to (or as a consequence of): Examiner 1 month Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2: autopsy performed? Yes AN No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural 2 ☐ Accident Injury 1 Tes 2 🗆 No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Farhad Jamali, MD 31. Date filed (Month, Day, Year)

Jarwas

29c. License number

29d. Date signed (Month, Day, Year) 3/26/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Dr. Greenbelt, MD 20770

29b. Signature and title of certifies

32. Registrar's Signature MAR 2 7 2008

DHMH 17 Rev 1/2001

Registrar

2008

MAR 2 7

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) In cec Us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUI CHH HILL 21921 81 West mari 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL** 

State Registrar

DHMH 17 Rev 1/2001

Die

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:00AM JAMES WILSON KERR III MARCH 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. MARY'S CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 IF MAY 21,1921 MARYLAND Director 215-12-7267 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director ST. MARY'S CHARLOTTE HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 CHARLOTTE HALL ROAD 20622 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23, any Injury or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 **PHYSICIST** U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES WILSON KERR II

LAURA VIRGINIA WRIGHT

19a. Informant's Name/Relationship (Type. Print) JANICE W. BAIN-KERR/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO BOX 1537, EASTON, MD 21601

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Date CHESAPEAKE CREMATION CTR 3/19/2008 STEVENSVILLE, MD 22. Name and Address of Facility

Strough C.F-SP Joseph m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line.

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601

Immediate Cause (Final disease or condition resulting in death) Due (or as a consequence

Securifiely list or differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

20a. Method of Disposition

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

20c. Location - City or Town, State

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

1 ☐ Inpatient

1 Yes 2 No 3 Probably 4 Unknown

INEN

24a. Was an autopsy perform 1∐ Yes 2 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of 2 1 No 1 TYes

Was case referred to medical examiner? examiner? 1 ☐ Yes 2 No Hospital: 27. Manger of Death

1 Natural 2 ☐ Accident

3□ Suicide

5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year) 28b. Time of

2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c, License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUIS V. KAUFMAN M.D., 12070 OLD LINE CENTER #207, WALDORF, MARYLAND 20602

State Registrar 31. Date filed (Month, Day, Year) MAR 2 0 2008

6 ☐ Could not be

determined



Baltimore, Maryland 21215-0036

**Physician** /Medical

Examiner

burial-transit

signed by the a d be detached for

After

ours after death.

leral Director: A
filled in by the fu

within 24 hours a

To the Funeral I

completely filled

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records. P.O. Box 68760

မ

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

|   |   |                  |   | Pleas                             | se Type o                                       |                                |  |                                |  |                              |                                   |                                      |                         | -                       | le.                           |                          |                             |
|---|---|------------------|---|-----------------------------------|---|--------------------------------|--|--------------------------------|--|------------------------------|-----------------------------------|--------------------------------------|-------------------------|-------------------------|-------------------------------|--------------------------|-----------------------------|
|   |   |                  | for<br>State  |                                   | State   | of Ma                          | aryland                                |                                | artment of<br><i>rtificate o</i>                     |                              |                                   | -                                    | _                       | 20                      | 0.0                           | Book                     | 1000                        |
|   |   |                  | Registrar  1. Decedent's Nam  | e (First, Middle                  | . Last)   |                                |  | Cei                            | rincate o  | Dec                          | alli                              | 2. Date of De                        |                         | - K-14                  | UO                            | 3. Time                  | of Death                    |
|   | Physicia<br>/Medic  |                  | Linda   |                                   | cille   | K                              | ing                                    |                                |  |                              |                                   | Month O                              | Day                     | 1 - 6                   | Year                          | 11.                      | 45 AM                       |
|   | Examin  |                  | 4a. Facility Name (/  |                                   |   | ,                              |  |                                | 4b. City, Town                                       |                              |                                   |                                      | 4c.                     | County o                |                               | 7                        |                             |
|   |   |                  | Carroll  5. Social Security N                                       |                                   | Hospita<br>6. Sex                               | _                              |  | ast birthday)                  | Westmi   |                              | er<br>Under 24 Hrs.               | 8. Date of Bir                       | rth                     |                         | rro1                          | ace (Stat                | e or Foreign                |
|   | Funeral Director  |                  | 218-40-   |                                   | 1□M 2\F   |                                | 64                                     | Yrs.                           | Months Day   | s Ho                         | ours Min.                         | July 2                               | 9 19                    | 43                      | Dela                          | ware                     | !                           |
| 1                                       | and the same  |                  | Usual Residence of<br>10a. State                                    | Decedent<br>10b. County           |   |                                | 10c. City                              | r, Town or Lo                  | ocation  |                              |                                   |                                      |                         |                         | 10                            | Od. Inside               | City Limits                 |
|   | maryi<br>t-f sho<br>fied a  | tor              | MD  | Carrol                            | .1  |                                |  | E10                            | dersburg   |                              |                                   |                                      |                         |                         |                               | 1 □ Y                    | es 2∏No                     |
| 1                                       | or 28g  | Funeral Director | 10e. Street and Nu  | mber                              | 114   |                                |  |                                | 10f. Zip Code  |                              |                                   |                                      | _                       | zen of WI               |                               |                          |                             |
|   | s 23a   | erall            |   | denour                            | Way, Apt  |                                |  | 2 12                           | 217  |                              | nio Origin? (Sn                   | acify Vac or No                      |                         | ted<br>14. Race         |                               |                          |                             |
| 0                                       | r item<br>iner r  |                  | <ol> <li>Marital Status</li> <li>Never Marr</li> </ol>              | ried 2. <mark>∏a</mark> Marri     | Armed   | Forces?                        |  |                                | Was Decedent of<br>If Yes, specify C                 |                              |                                   | Rican, etc.)                         |                         | Black                   | , White, e                    |                          |                             |
| 2                                       | ours a<br>iral", o<br>Exan  | d by             | 3 🗌 Widowed   |                                   | If Yes, 0<br>Year or                            | Dates:                         | ······································ |                                | 1□Yes 2∏XN   |                              | pecify:                           |                                      |                         | Specify:                |                               | white                    | е                           |
| ה ל                                     | n / z n<br>n "natu<br>edical  | lete             |   |                                   | t grade completed                               | •                              |  | 16a. Dece<br>(Give<br>life,    | dent's Usual Oc<br>kind of work do<br>DO NOT use ret | upation<br>ne during<br>red) | n<br>ng most of work              | ing                                  | 16b. Ki                 | ind of Bus              | siness/Ind                    | lustry                   |                             |
| 7 7                                     | giene.  | Completed        | Elementary/Second 1   | ondary (0-12)<br>. 2              | College   | (1-4or 5                       | i+)                                    |                                | emaker   |                              |                                   |                                      | c                       | own h                   | ome                           |                          |                             |
| מומ                                     | d othe  | Be               | 17. Father's Name   | _                                 |   |                                |  |                                |  | 18.                          |                                   | e (First, Middle                     |                         |                         |                               |                          |                             |
| 2                                       | permit. Pages I and 2 should be the within 72 hours after death with the maryland<br>permit. Pages I and Mental Hygiene. Important; if them 27 is marked other than "natural", or items 23a or 28a-f show<br>any injury or other traumatic event, the Medical Examiner must be notified at<br>once.                                 | 은                | Elijah  19a. Informant's N  | J.                                | Ayde  | elot                           | te                                     | 19b. Maili                     | ng Address (Stre                                     | et and I                     | Fannie                            |                                      | lla<br>per. City o      |                         | vans<br>State Zin             | Code)                    |                             |
|   | alth an 27 is is trau   |                  | Robert  |                                   |   | spou                           | se                                     |                                | 8 Rideno   |                              |                                   |                                      |                         |                         |                               | ,                        | 1784                        |
| ָב<br>ב                                 | of Hei  |                  | 20a. Method of Dis  | position                          | 3 ☐ Removal fro                                 | n State                        | 20b. Pl                                | lace of Dispo                  | osition (Name of<br>matory or other p                |                              |                                   | Date                                 |                         | ocation - C             |                               |                          |                             |
| Dalullion                               | rtment<br>rtant:<br>njury o   |                  | 4 Donation  | 5 ☐ Other (S                      | pecify)   |                                | A11                                    |                                | ts Cemet   |                              |                                   |                                      |                         | nder1                   |                               |                          |                             |
| ם<br>ח                                  | Depar<br>Impor<br>any Ir  | 4                | 21 Signature of the   | uneral Service                    | icensee   | -                              |  | 2                              | 2. Name and Ad                                       |                              |                                   | mony La                              |                         |                         | -                             |                          | 0736                        |
| н                                       | 712   |                  | 23a. Part1. Enter t   | the disease, or                   | complications tha                               | caused                         | the death                              | n. Do not en                   |  | -                            |                                   |                                      |                         |                         |                               | Approxin                 | nate<br>Between             |
|   | hysician  |                  | Immediate Cause<br>disease or condition                             | (Final                            | a. <  | 56                             | PT                                     | C                              | SHO  | 00                           | K                                 |                                      |                         |                         |                               | Onset ar                 | nd Death                    |
|   | /Medical<br>Examiner  |                  | resulting in death)   |                                   | Due t   | o (or as                       | a consequ                              | ence of):                      | DAI  |                              | DNIC                              | Uma                                  | 212                     | 2 A                     | - 1                           | 0,1                      | 3745                        |
|   | no AST  | Jer              | Sequentially list co<br>if any, leading to in<br>cause. Enter Under | onditions,<br>nmediate            | b   | o (or as                       | a consequ                              | uence of):                     | 17/10  | _                            | 1/00                              | 0 1170                               | // -                    | ' P }                   | V                             | ew                       | 2//(3                       |
|   | executed<br>in and<br>rial-transit  | Examiner         | Cause (Disease or that initiated events resulting in death)         | 'injury<br>s                      | С   |                                |  |                                |  |                              |                                   |                                      |                         |                         |                               |                          |                             |
| Ç,                                      | be exe<br>ician a<br>burial-  |                  | resulting in death)   | Last                              | Due t   | o (or as                       | a consequ                              | ience of):                     |  |                              |                                   |                                      |                         |                         |                               |                          |                             |
| 00                                      | g phys  | Physician/Medica |   |                                   | d   |                                |  |                                |  |                              |                                   |                                      |                         |                         |                               |                          |                             |
| מאל ל                                   | tendin<br>r use   | an/M             | IF FEMALE:<br>23b. Was deceder<br>in the past 12                    |                                   | 23c. If yes, o                                  |                                | pf pregna<br>2 □ Fetal                 |                                | ⊒Ectopic pregna                                      | ncy                          |                                   |                                      |                         | 23d. Date<br>Mon        |                               | ery<br>Day               | Year                        |
| 5                                       | the at  | ysici            | 1 ☐ Yes 21<br>9 ☐ Unknowr   | <b>X</b> 000                      | 4□Pre<br>9□Unl                                  |                                | t time of de                           | eath 5[                        | Other (specify                                       |                              |                                   |                                      |                         | I NOT                   |                               | Day                      | 700                         |
| ֡֡֝֝֝֓֜֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | The faw requires that the death cermicate be ate has been signed by the attending physicial page 2 should be detached for use as the bur  | by Ph            | Part II, Other signi  | ficant condition                  | ns contributing to                              | death b                        | ut not resu                            | Ilting in the u                | Inderlying cause                                     | given in                     | Part I.                           | 23e. Did                             | tobacco u               | use contri              | bute to th                    | e cause                  | of death?                   |
| ecords,                                 | equire<br>sen sig<br>rould b  | ted b            | ONG   | Only                              | OUE   |                                |  | DIA                            | 136/   | <u>22</u>                    | · ·                               | 1 🗆                                  | Yes 2                   | XNo :                   | 3 ☐ Prob                      | ably 4                   | □Unknown                    |
| ב<br>ב                                  | has bu  | Completed        | ST  | APT                               | (5/   | 10                             | TE                                     | - PLE                          | = (1)(   | T                            |                                   | 24a. Was                             | psv                     | l pi                    | Vere autorior to cor<br>eath? | psy findin<br>npletion o | gs available<br>if cause of |
| VII                                     | ifficate<br>or, pag   |                  | 25. Was case refer  | rred to medical                   |   |                                |  |                                |  | 26                           | Place of Deat                     | 1 Yes                                | ormed<br>2 No           | 1                       |                               | 2□ No                    |                             |
| >                                       | nis cer<br>direct   | To Be            | examiner?<br>1 ☐ Yes  | 7                                 | Hospital:                                       | Inpatie                        | ent 2 🗆 I                              | ER/Outpatie                    | nt 3□ DOA  | ther:                        |                                   | ome 5□Res                            |                         | 6 □Othe                 | er (Specify                   | v)                       |                             |
|   | After t   |                  | 27. Manner of Dear  | 5 Pendin                          |   | e of Inju<br>onth, Da          |  | 28b. Time o<br>Injury          | V  | jury at<br>Vork?             | оПМа                              | 28d. Describe                        | how inju                | ry occurre              | ed                            |                          |                             |
|   | death<br>ctor:  | ficat            | 2 ☐ Accident 3 ☐ Suicide  | investig<br>6 ☐ Could r<br>determ | ot be 28e. Pla                                  | ce of inj                      | ury - At ho                            | me, farm, st                   | reet, factory, offi                                  |                              | 2 □ No                            | 28f. Location                        |                         |                         | er or Rura                    | I Route N                | lumber,                     |
| 5 3                                     | ral or safter all Directions and Direction bed in the   | Certification:   | 4  Homicide   |                                   | bul   |                                | c. (Specify                            |                                |  |                              |                                   | City or To                           |                         |                         |                               |                          |                             |
| 1                                       | To the hospital or Attending Priystrant. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical          | 29a. Certifier<br>(Check only<br>one)                               | 1 CertifyIn<br>2 Medical          | g Physician: To t<br>Examiner: On the<br>and ma | he best<br>basis o<br>anner st | f examinat                             | wledge, deat<br>tion and/or in | th occurred at the<br>nvestigation, in n             | time, o<br>y opinio          | date and place,<br>on, death occu | , and due to the<br>rred at the time | e cause(s<br>e, date an | ) and mar<br>d place, a | nner as si<br>ind due to      | tated. the caus          | se(s)                       |
| i.                                      | Withir North  | Me               | 29b. Signature and  | Title of certifier                | 2/11  | a                              | M                                      | 1)                             | 29c. Lice  | ense nui                     | imber                             |                                      | 29d. Da                 | te signed               | (Month,                       | Day, Yea                 | r)                          |
|   |   |                  | 70 Nr.  | Land                              | uho on saluti                                   |                                | laath (!                               | 02a) /T                        | Definit)   | 9                            | 790                               |                                      | M                       | arch                    | 21,                           | 2008                     | }                           |
| gh                                      | 6   |                  | Name and add  | 770 (                             | Wild completed ca                               | 2 2                            | 24 (Item                               | WA (Type                       | SHING  | 10                           | W+17                              | 3.4                                  | KST                     | 201                     | 20                            | 211                      | 57                          |
|   | Sta<br>Registr  | ite<br>ar        | 30. Name and add  | nth, Day, Year)                   | 2 7 200   | Registr                        | ada Signa                              | ture                           | April  |                              |                                   |                                      |                         |                         |                               |                          |                             |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year DORIS F. LEONARD March 25 2008 2:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours 88 1919 MARYLAND OCT 18. 216-18-8908 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No ROYAL OAK MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21662 24792 DEEP NECK ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KATHERINE FISHER ARTHUR FARMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6197 WATERLOO DRIVE, EASTON, MARYLAND 21601 KATHERINE L. CALLAHAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/29/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN MERCERO R Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonit days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed physician an s the burial-tr Division or Vital Records, P.O. Box 68760. ası attending p has

Examine Completed by Physician/Medical Be ၉ Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or ?

the Medical

other

77 is marked o

Department of Heal Important; If Item 2 any Injury or other once.

Physician

/Medical

Examiner

Health and tem 27 is r

death

1 and 2 should be filed within 72 hours after

Pages 1

Maryland 21215-0036

Baltimore, Doris

Leonard

Director

Funeral

Completed

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death | Director: / d in by the f Funeral Di

15-

State

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated.

3.26.08

30. Name and address of person who completed cause of death wem 23a) (Type Print) (ROWLEY

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

DUTCHMAN'S LANG 610

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

|                                |   |                | For<br>State<br>Registrar                 |                                      | State of M  | larylan       |                                | artment o                             |  | d Mental H                                   | ygiene<br>Reg. No. 2                | 008                           | 1193   |
|--------------------------------|---|----------------|---|--------------------------------------|---|---------------|--------------------------------|---------------------------------------|--|--|-------------------------------------|-------------------------------|--|
|                                |   | 3              | 1. Decedent's Name (                      | First, Middle, La                    | st)   |               |                                |                                       |  | 2. Date of I<br>Month                        | Death Day                           | Year                          | 3. Time of Death                               |
| 2                              | Physici<br>/Medic   |                | SHEILA FA                                 | AYE VAN                              | LOON  |               |                                |                                       |  | MARCI  |                                     | 2008                          | 10:35AM <sup>M</sup>                           |
|                                | Examir  |                | 4a. Facility Name (If no                  |                                      |   | )             |                                | 4b. City, Tow                         | n, or Location of D                      | eath   | 4c. Cou                             | nty of Death                  |  |
|                                |   | 3              | MEMORIAL                                  |                                      |   |               |                                |                                       | EASTON                                   |  |                                     | TALE                          |  |
|                                | Funeral<br>Director   |                | 5. Social Security Num 199–22–07          | 69                                   | 7. A  | ge (In yrs. 1 | last birthday<br>Yrs.          |                                       |  | Hrs. 8. Date of I (Month, SEPT)              | Birth<br>Day, Year)<br>10,1928      | 9. Birthp<br>Coun             | lace (State or Foreign<br>try) PA              |
| 4                              | and<br>w<br>t   |                | Usual Residence of De<br>10a. State 1     | Ob. County                           |   | 10c. City     | y, Town or L                   | ocation                               | - 30                                     |  |                                     | 1                             | 0d. Inside City Limits                         |
| _                              | f sho   | ō              | MD  | TALBO                                | <b>ੀ</b> ਧਾ   |               | CT                             | . MICHA                               | I/T C                                    |  |                                     |                               | 1 □ Yes <b>X</b> No                            |
| SHE                            | the 28a   | Director       | 10e. Street and Numb                      |                                      | 71  |               | 91                             | 10f. Zip Cod                          |  |  | 10g. Citizen                        | of What Coun                  | itry?  |
| 士                              | 3a ol   |                | 207 TYL                                   | ER AVE.                              |   |               |                                | 2                                     | 1663                                     |  | US                                  | :A                            |  |
| S                              | death<br>ms 2   | Funeral        | 11. Marital Status                        |                                      | 12. Was Decedent  | t Ever in U.  | .S. 13.                        |                                       |  | ? (Specify Yes or I                          |                                     | Race - Americ                 |  |
| 79                             | after<br>or ite<br>mlne   | Ē              | 1 Never Married                           | 2 Married                            | 1 Yes 2   |               |                                | 1 ☐ Yes 2 🙀                           |  | uerto nicari, etc.)                          |                                     | Black, White,                 | etc.   |
| 28                             | ours<br>iral",  | d by           | 3 Widowed 4                               | Divorced                             | Year or Dates:  |               |                                |                                       |  |  | Spe                                 | WE                            | HITE   |
| O'Y                            | 72 h<br>'natu<br>dical  | etec           | (Specify                                  | 5. Decedent's Ed<br>only highest gra | ducation<br>ade completed)                                  |               | ı (Giv                         | edent's Usual Oc<br>e kind of work do | one durina most of                       | working                                      | 16b. Kind of                        | Business/Ind                  | dustry   |
| 75                             | be filed within 72 hours after death with the Maryland<br>ttal Hyglene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | Completed      | Elementary/Second                         | ary (0-12)                           | College (1-4or  | 5+)           |                                | DO NOT use re                         | ,  |  | -                                   | I EDUAL                       | who  |
| 32                             | Hed v<br>Hygie<br>Her t   |                | 12<br>17. Father's Name (Fit              | ret Middle Laet                      | 0   |               |                                | PERVISO:                              |  | Name (First, Midd                            |                                     | LEPHON                        | (E   |
| /Ar                            | d d d   | To Be          | WALTER MO                                 |                                      |   |               |                                |                                       |  | INNIE SCI                                    |                                     |                               |  |
| ar                             | ges 1 and 2 should<br>t of Health and Men<br>If item 27 is marke<br>or other traumatic  |                | 19a. Informant's Nam                      | e/Relationship (                     | Type. Print)  |               | 19b. Mail                      | ing Address (Str                      | reet and Number o                        | or Rural Route Nur                           | nber, City or Tov                   | vn, State, Zip                | Code)  |
| Σ.                             | and 2<br>salth<br>n 27 i  | 38             | KENNETH VA                                | AN LOON,                             | HUSBAND   |               |                                |                                       |  | HAELS, MA                                    |                                     |                               |  |
| ore                            | ges 1<br>if of He<br>or oth   |                | 20a. Method of Dispos                     |                                      | Removal from State  |               | Place of Disp<br>cemetery, cre | osition (Name o<br>ematory or other   | f<br>place)                              | Date   | 20c. Location                       | n - City or To                | wn, State                                      |
| <u><u>E</u></u>                | Pag<br>ment<br>ant: I<br>ury o  |                | 4 □ Donation 5                            |                                      |   |               | FORD C                         | EMETERY                               | !<br>!                                   | 3/27/2008                                    | OXFOR                               | D, MAR                        | RYLAND   |
| Baltimore, Mary                | permit. Pag<br>Department<br>Important: I<br>any injury o<br>once.  |                | 21. Signature of Fune                     | ral Service Lice                     | Ostanick  | . CF.         | F                              | ELLOWS.                               | HELFENB                                  | EIN & NEV                                    | NAM FUN                             | ERAL E                        | IOME PA  |
|                                |   |                | 23a. Part1. Enter the                     | disease, or com                      | plications that cause<br>one cause on each                  | ed the death  |                                |                                       |  |  |                                     |                               | Approximate<br>Interval Between                |
|                                | Physician   | 8 4            | Immediate Cause (Fir disease or condition |                                      |   |               | man                            | ia                                    |  |  |                                     |                               | Onset and Death                                |
|                                | /Medical  |                | resulting in death)                       |                                      | a. Due to (or a   |               |                                | 1                                     |  | ſ  |                                     |                               | I Week   |
| k i                            | Examiner  |                | en and the second                         |                                      | Met   | ast.          | atie                           | 2                                     | sophas                                   | eal c  | ance                                | Y                             | 2 year   |
|                                | T ==  | ner            | Novakovitatili list avville pri           |                                      |   |               |                                |                                       |  |  |                                     |                               |  |
|                                | cate be executed physician and the burial-transit   | ami            | at initiated events and c.                |                                      |   |               |                                |                                       |  |  |                                     |                               |  |
| ó,                             | e exe<br>ian a<br>ırial-1   |                | resulting in death) Las                   | SI                                   | Due to (or a  | s a consequ   | uence of):                     |                                       |  |  |                                     |                               |  |
| 8760,                          | ate by  | dical          |   |                                      | d   |               |                                |                                       |  |  |                                     |                               |  |
| 9                              | ertifica<br>ing pl<br>e as t  | Med            | IF FEMALE:                                |                                      |   |               |                                |                                       |  |  | - 1                                 |                               | -  |
| Box                            | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as  | Physician/Me   | 23b. Was decedent point the past 12 mg    |                                      | 23c. If yes, outcom<br>1 ☐ Live birth                       | 2 🗆 Feta      | death 3                        | Ectopic pregna                        |  |  |                                     | Date of delive<br>Month       | ery<br>Day Year                                |
|                                | the a   | sic            | 1 ☐ Yes 2 ☐ N<br>9 ☐ Unknown              |                                      | 4□Pregnant a<br>9□Unknown                                   | at time of d  | leath 5                        | Other (specif)                        | y)                                       |  | -                                   |                               | Duy  |
| Α.                             | w requires that the de<br>been signed by the<br>should be detached  | Ph             | Part II. Other significa                  | ant conditions                       | contributing to death                                       | but not resi  | ulting in the                  | inderlying cause                      | e diven in Part I                        | 23e Di                                       | d tobacco use c                     | ontribute to th               | ne cause of death?                             |
| Š                              | ires t<br>signe<br>d be c   | by             | t at it. Out of organization              | ant domains is                       | orning to dod!!   | Dat 1.0t 100t | diang in the                   | and onlying oddoc                     | given in raici.                          |  | Yes 2 N                             |                               |  |
| Ö                              | requ  | Completed      |   |                                      |   |               |                                |                                       |  | _  |                                     |                               |  |
| Sec                            | ne law<br>has t<br>ge 2 s   | nple           |   |                                      |   |               |                                |                                       | *  | — 24a. W                                     | as an 24<br>topsy<br>rformed?       | b. Were auto<br>prior to coi  | psy findings available<br>mpletion of cause of |
| <u>=</u>                       | cate<br>pag   | ပိ             |   |                                      |   |               |                                |                                       |  | 1□ Yes                                       |                                     | death?<br>1 ☐ Yes             | 2□ No  |
| Vit                            | Physician: The la<br>r this certificate has<br>ral director, page 2   | Be             | 25. Was case referred examiner?           |                                      | Hospital:   |               |                                |                                       | 26. Place of Other:                      | Death (Check onl                             | y one)                              |                               |  |
| or                             | Phys  | 은              | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death     | )                                    | 28a. Date of Inj  |               | ER/Outpatie                    | III 3 DOA                             | 4 Li Nursi                               | ng Home 5 ☐ Re                               |                                     |                               | y)   |
| u                              | ding F<br>h.<br>After<br>funer  | ioi            | 1 Natural                                 | 5 ☐ Pending investigation            | (Month, D   | ay Year)      | Injury                         |                                       | Injuryat<br>Work?<br>1 ∐ Yes 2 ∐ No      |  | e how injury oc                     | curred                        |  |
| Sic                            | or Attendated after death Director: in by the   | icat           | 2 ☐ Accident<br>3 ☐ Suicide               | 6 ☐ Could not b                      |   | niury - At ho | ome. farm. s                   |                                       |  |  | (Street and No                      | mher or Rura                  | I Route Number,                                |
| Division or Vital Records, P.O | s after al Direct al Direct ed in by  | Certification: | 4 Homicide                                | determined                           | building, e   | etc. (Specif  | (y)                            | treet, factory, off                   |  | City or                                      | own, State)                         | o, or riula                   |  |
|                                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,                | Medical (      | 29a. Certifier 1]<br>(Check only one) 2   | ☐ Certifying Pl☐ Medical Exa         | nysician: To the bes<br>miner: On the basis<br>and manner s | of examina    | wledge, dea<br>ation and/or i  | th occurred at the                    | ne time, date and p<br>my opinion, death | place, and due to to<br>occurred at the time | ne cause(s) and<br>ne, date and pla | manner as s<br>ce, and due to | tated.<br>the cause(s)                         |
|                                | oth<br>vithin<br>oth<br>ompl  | Me             | 29b. Signature and titl                   | le of certifler                      | 4   |               |                                | 29c. Lic                              | cense number                             |  | 29d. Date sig                       | ned (Month,                   | Day, Year)                                     |
|                                | ->- O   |                | 100                                       | o a . V                              | A,  | M             | $\cap$                         | Fa                                    | 002981                                   | 0  | Marc                                | h a                           | 2.2008   |

Registrar DHMH 17 Rev 1/2001

State

Danie

31. Date filed (Month, Day, Year) MAR 2 5 2008

washington

Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Abraham, 219 S.

|                            | Amend   | #3             | State<br>Registrar 32, TCHD  | 03/25/08, pl   | na <i>Ce</i>                   | rtificate                             | of Death   |                            | Reg. No.                              | 108                  |   | 93                   |
|----------------------------|---|----------------|--|--|--------------------------------|---------------------------------------|--|----------------------------|---------------------------------------|----------------------|---|----------------------|
|                            | Dhysisi   |                | 1. Decedent's Name (First, Middle, La  | ast)   |                                |                                       |  | 2. Date of De<br>Month     | eath<br>Day                           | Year                 | 3. Time                                       | e of Death           |
| L                          | Physici<br>/Media   |                | ROBERT   | G.   |                                | LAU                                   |  | MARCH                      | 22, 20                                | 800                  | 134   | 44                   |
|                            | Examir  |                | 4a. Facility Name (If not institution, gi  | e street and number)                                   |                                | 4b. City, To                          | wn, or Location of Death                             |                            | 4c. Cour                              | nty of Death         | 1   |                      |
|                            |   | 1.00           | 3100 BEAVER LANE   |  |                                | TRA                                   |  |                            |                                       | BOT                  |   |                      |
|                            | Funeral   |                |  | Sex 7. Age (//<br>1 <b>X</b> ∑M 2□ F                   | n yrs. last birthday)<br>Yrs.  | If Under 1 \ Months C                 | Year If Under 24 Hrs. Days Hours Min.                | 8. Date of Bi<br>(Month, D | ay, Year)                             | Cou                  | iplace (Sta<br>intry)                         |                      |
|                            | Director  |                | 134-34-0136 Usual Residence of Decedent  | 4  | 63                             |                                       |  | AUG. 1                     | 0, 1944                               | +                    |   | PA.                  |
|                            | and and   |                | 10a. State 10b. County   | 10   | c. City, Town or Lo            | ocation                               |  |                            |                                       |                      | 10d. Inside                                   | e City Limi          |
|                            | Maryl<br>f sho  | ō              | MD TALE  | <b>ሰ</b> ሞ   | TRAP                           | DIF                                   |  |                            |                                       |                      | 1 🗆 Y   | res 2X1              |
|                            | the 28a-  | Director       | 10e. Street and Number   | OI   | TIVIT                          | 10f. Zip Co                           | ode  | I                          | 10g. Citizen o                        | of What Cou          | untry?  |                      |
|                            | 3a or   | Ö              | 2100 DEATED TAN  | ישר  |                                |                                       | 21673  |                            |                                       | TTC                  | · A   |                      |
|                            | ms 2:   | Funeral        | 3100 BEAVER LAN  | 12. Was Decedent Eve                                   | r in U.S. 13.                  | Was Deceden                           | nt of Hispanic Origin? (Sp<br>Cuban, Mexican, Puerto | ecify Yes or N             | o- 14. R                              | us<br>ace - Ameri    | ican Indian                                   | 1,                   |
| (0                         | or itel   |                | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?  |                                |                                       |  | Hican, etc.)               |                                       | lack, White          |   |                      |
| 03                         | ours after death with the Marylan<br>ral", or items 23a or 28a-f show<br>Examiner must be notified at   | b              | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                         |                                | 1□Yes 2□                              | No Specify:  |                            | Spe                                   | cify: WHI            | TE  |                      |
| 215-0036                   | 72 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>sdical Examiner must be notified at  | Completed      | 15. Decedent's E<br>(Specify only highest g  | ducation<br>ade completed)                             | (Give                          | dent's Usual C                        | done during most of work                             | kina                       | 16b. Kind of                          | Business/I           | ndustry                                       |                      |
| 21                         | ithin<br>ne.<br>nan "   | ldu            | Elementary/Secondary (0-12)  | College (1-4or 5+)                                     | life.                          | DO NOT use i                          | retired)   |                            |                                       |                      |   |                      |
| 2                          | filed within<br>Hygiene.<br>Ither than "  | ပ်             | 12   | 0  | COLO                           | K LITH                                | OGRAPHER   | - /5:                      | 14-14 0                               | PRINT                | LNG   |                      |
| P                          | be fill<br>d oth<br>even  | Be             | 17. Father's Name (First, Middle, Las  | t)   |                                |                                       | 18. Mother's Nam                                     |                            | e, Maiden Surn                        | ame)                 |   |                      |
| yla                        | 2 should be filed within n and Mental Hygiene. Is marked other than " raumatic event, the Med   | 잍              | GEORGE W. LAU  |  | 1                              |                                       | LUCILLE  |                            |                                       |                      |   |                      |
| Maryland                   | s 1 and 2 should be filed within 72 hc<br>I Health and Mental Hygiene.<br>Item 27 Is marked other than "natun<br>other traumatic event, the Medical                                 |                | 19a. Informant's Name/Relationship   |  |                                | ,                                     | Street and Number or Ru                              |                            |                                       |                      | ip Coae)                                      |                      |
|                            | 1 and 2<br>Health<br>em 27 l  |                | HEATHER V. WESTE<br>20a. Method of Disposition   |  | TER 720<br>20b. Place of Dispo |                                       | CES ST., EAS   | STON, M                    | D 21601<br>20c. Locatio               |                      | Fown State                                    | <u> </u>             |
| Baltimore,                 | 0 0 <del>-</del> -  |                | 1 ☐ Burial 2 XCremation 3  |  | cemetery, cre                  | matory or othe                        | erplace)   |                            |                                       |                      |   |                      |
| Ħ                          | t. Pa<br>tmer<br>tant:  |                | 4 □ Donation 5 □ Other (Spec   | -  |                                |                                       | MATION CTR   | 3/25/20                    | 08 STEV                               | ENSVI                | LLE,  | MD                   |
| Bal                        | permit. Pag<br>Department<br>Important: I<br>any injury o   |                | 21. Signature of Funeral Service Lice  | ensee  | F                              | ELLOWS.                               | Address of Facility  HELFENBET                       | N & NEW                    | NAM FUN                               | ERAL                 | HOME  | PA                   |
|                            | ED = # 0  |                | JOHN R.  | MERCER   | 20~ 2                          | 00 S. I                               | HARRISON ST  | EASTON                     | , MD 21                               | 601                  | Approxi                                       |                      |
| п                          |   |                | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only  | nplications that caused the<br>one cause on each line. | death. Do not en               | 11                                    | , 1  | 1                          |                                       | //                   | <ul> <li>Interval</li> <li>Onset a</li> </ul> | Between<br>and Death |
|                            | Physician   |                | Immediate Cause (Final disease or condition resulting in death)  | a. 192/2/0   | te day                         | Gross                                 | Frolle ca  | dievas                     | crifed .                              | 11500                | M   |                      |
|                            | /Medical<br>Examiner  |                | Tooding in doding  | Due to (or as a co                                     | onsequence of):                |                                       | , , , ,  |                            |                                       |                      |   |                      |
| 8                          |   | 1              | Sequentially list conditions,  | b<br>Due to (or as a co                                | onsequence of).                |                                       |  |                            |                                       |                      |   |                      |
|                            | ted   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | 540 (0, 40 4 0)  | onocquence on.                 |                                       |  |                            |                                       |                      |   |                      |
|                            | xecu<br>and<br>al-trai  | xar            | that initiated events<br>resulting in death) Last  | c<br>Due to (or as a co                                | onsequence of):                |                                       |  |                            |                                       |                      |   |                      |
| 09                         | be e<br>iician<br>buria   |                |  |  |                                |                                       |  |                            |                                       |                      |   |                      |
| 68760,                     | certificate be executed ding physician and se as the burial-transit   | /Medical       |  | -d   |                                |                                       |  |                            |                                       |                      |   |                      |
| ×                          |   |                | IF FEMALE:   | 23c. If yes, outcome pf p                              |                                |                                       |  |                            | 23d.                                  | Date of deli         | verv  |                      |
| B                          | atten<br>for us   | ciar           | in the past 12 months?   | 1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim              |                                | ⊒Ectopic preg<br>⊒Other <i>(sp</i> ec |  |                            | 1                                     | Month                | Day   | Year                 |
| P.0.                       | the d<br>y the  | Physician      | 9 Unknown  | 9□Unknown  |                                |                                       |  |                            |                                       |                      |   |                      |
| σ.                         | Attending Physician: The law requires that the death refeath. ector: After this certificate has been signed by the atter by the funeral director, page 2 should be detached for up. | y P            | Part II. Other significant conditions  | contributing to death but n                            | ot resulting in the u          | ınderlying cau:                       | se given in Part I.                                  | 23e. Did                   | tobacco use c                         | ontribute to         | the cause                                     | of death?            |
| ds                         | juires<br>n sigr  | d by           |  |  |                                |                                       |  | 1 🗆                        | Yes 2□ No                             | 3 🗆 Pro              | obably 4                                      | Unkno                |
| Ö                          | w require<br>been sign  | Completed      |  |  |                                |                                       |  | 24a. Wa                    | s an 24                               | b. Were au           | topsy findii                                  | ngs availa           |
| Re                         | he lav<br>e has   | dm             | THE PARTY OF THE P |  |                                |                                       |  | auto<br>per                | opsy<br>formed?                       | prior to c<br>death? | completion                                    | of cause of          |
| ā                          | ician: Th<br>certificate<br>ector, pag  | ပိ             | 25. Was case referred to medical   | 1  |                                |                                       | 26 Plans of Dec                                      | 1□ Yes                     | 22 No                                 | 1 🗆 Yes              | 2 No  |                      |
| Division or Vital Records, | yslcian: The is certificate hadirector, page  | Be.            | examiner?  | Hospital: 1 ☐ Inpatient                                | 2 ER/Outpatie                  | nt 3 DOA                              | 26. Place of Dea                                     |                            |                                       | Othor (Coo           | 3/6 A   |                      |
| ō                          | Physer this eral di   | : To           | 27. Manner of Death  | 28a. Date of Injury                                    | 28b. Time of                   |                                       | c. Injury at<br>Work?                                | - 2                        | how injury oc                         |                      | ny)   |                      |
| on                         | ding F<br>th.<br>: After<br>s funera  | tior           | 1 ☐ Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Yo   | ear) Injury                    | М                                     | Work?<br>1 ☐ Yes 2 ☐ No                              |                            |                                       |                      |   |                      |
| /isi                       | Atter<br>dea<br>ector   | fica           | 3 ☐ Suicide 6 ☐ Could not  | 20e. Flace of illjury                                  | - At home, farm, st            | reet, factory, o                      | office   | 28f. Location              | (Street and Nu                        | mber or Ru           | ıral Route i                                  | Number,              |
| ă                          | al or<br>after<br>i Dir<br>d in t   | Certification: | 4 ☐ Homicide determine   | building, etc. (                                       | <i>Бреспу)</i>                 |                                       |  | City or 10                 | own, State)                           |                      |   |                      |
|                            | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral  |                |  | hysician: To the best of n                             |                                |                                       |  |                            |                                       |                      |   | unn (=)              |
|                            | n 24  <br>n 24  <br>ne Fu   | Medical        | (Check only 2 Medical Example)   | amIner: On the basis of ex<br>and manner stated        | arnination and/or i            | ivestigation, ir                      | n my opinion, death occu                             | irred at the time          | , date and pla                        | e, and due           | to the cau                                    | se(S)                |
|                            | To th<br>Vithii<br>To th  | Ž              | 29b. Signature and title of certifier  | (1)  | MA I                           |                                       | icense number  |                            | 29d. Date sig                         | ined (Month          | h, Day, Yea                                   | ar)                  |
|                            |   |                | 100  | 2  | 100                            | 1                                     | 25750  | ,                          | 3/2                                   | -4/0                 | 8   |                      |
|                            | 8   |                | 30. Name and address of person who   | completed cause of deat                                | h (Item 23a) (Type             | , Print)                              |  |                            | · · · · · · · · · · · · · · · · · · · |                      |   |                      |

e 6 Other (Specify) injury occurred et and Number or Rural Route Number, State) use(s) and manner as stated. te and place, and due to the cause(s) I. Date signed (Month, Day, Year) ROBERT B. SANCHEZ M.D., 508 IDLEWILD AVE., EASTON, MD 21601 MAR 2 5 2008 Seem & Jane

Birthplace (State or Foreign Country)

PA 10d. Inside City Limits 1 ☐ Yes 2X No

4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ALICE MARIE LINTON 2008 5 8:10 a. April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 91 214-10-2122 Director June 12, 1916 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 14. Race - American Indian, 9507 Hamburg Road 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Health Care 12 should be filed w h and Mentał Hygier 7 Is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Montail Important: If them 27 is marked of any injury or others. Be Charles Edgar Baker Rosa Clara Kinna ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merle Gaver/nephew 8 Poplar Street, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Zion U.Methodist 5 ☐ Other (Specify) Apr.9, 2008 Myersville, Maryland of F eral Service 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence offi-Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as the l attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 a for Day Yea 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 🎾 No 3 🗆 Probably 4 🗆 Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy death? 1 ☐ Yes 2 ☐ No performed' Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA this / 은 1 | Inpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funeral Manner of Veath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnet stated. (Check only / 24 To the

State Registrar

DHMH 17 Rev 1/2001

within

MD,

29b. Signature and title of certifier

Casper Cline

31. Date filed (Month, Day, Year)

30 Name and adder

32. Registrar's Signature

300 West 9th Street,

of death (Item 23a) (Type, Print)

29c. License number

Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** BETTY CAROL COATES LOCKS a M 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Deat Examiner Plata Medical har Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 200 Months Hours Director 212-80-7145 48 AUG.31,1959 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 GARNER AVENUE 20602 S. Funeral Α. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married ★★Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK \$ Baltimore, Maryland 21215-003 72 hours 3 Widowed 4 Divorced "natural". Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE PROVIDER HEALTH DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES NEAL ဥ IRENE COATES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS LOCKS / HUSBAND 605 GARNER AVE., WALDORF, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 APRIL Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. MARY'S CEMTRY 10,2008 PRICE P.A. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. TA DI.ATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi certificate be executed and resulting in death) Last P.O. Box 68760. attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4⊡Pregnant at time of death 5 ☐ Other (specify) detached the 9☐ Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate or Vital 1☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of perso ho completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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VISTa

32. Registrar's Signature

**Physician** /Medical Examiner **Funeral** Director death with the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after ealth and Mental Hygiene.

n 27 is marked other than "natural", or ite Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai **Physician** /Medical **Examiner** attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760 signed by the at d be detached for this

326 Martins Cove Road 21409 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer 5+17. Father's Name (First, Middle, Last) Be Carl William Malone ပ 19a. Informant's Name/Relationship (Type. Print)
Eloise Malone/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a consequence of) No Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events routling in death). Due to (or as a consequent Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 25 No P npatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D0065829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day David William Malone  $P^{M}$ 25 9:24 March 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Age (In yrs. last birthday) Months <sup>Year)</sup> 1938 XXM 2□ F 570-46-1439 69 California Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits Anne Arundel Annapolis Maryland 1 □Yes 2XXNo Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code U.S.A. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Consulting 18. Mother's Name (First, Middle, Maiden Surname) Juanita Kellv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21409 326 Martins Cove Road Annapolis, Maryland 20c. Location - City or Town, State 3/31/2008 Davidsonville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Cente, Amas Medica HowAnD MD Anne 31. Date filed (Month, Day, 32. gistrar's Signature

Reg. No.

3 Time of Death

Registrar

MAR 2 7 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Virginia S. Mac Fadden March 06:15 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 07/08/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Director 265-54-9178 87 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or iteme 23a 800 Bestgate Road 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Item any injury or other treumatic event, the Midigal Exercises 2009. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:White ٥ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred B. Schilling Helen Davelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Schmidt/Daughter 6276 Old Solomons Island Rd., Friendship, MD 20758 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Kalas Crematory 03/27/2008 Ed ewater, Maryland Service Licensee 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home Cul 2973 Solomons Island Rd.,Edgewater, MD 21037 a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5ta **Physician** /Medical Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hoepitel or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien end the attending physicien end thed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not/esvilting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitas 2 No. 3 Probably 1 🗌 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes '25 No 2 1 Sin atient 2 ER/Outpatient 3 DOA After thi funeral of 27. Manyfer of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) mpleted cause of death (Item 23a) (Type, Print) mD 116 32. Figistrar's Signature 31. Date filed (Month, Day, State Registrar

|                |  |                        | 1 arignd #5 Per F  | H G878 4/1  | f Maryland<br>. <b>8/08 JH</b>   | / Depa                                 | artment of H<br>rtificate of L                          | ealth a<br>D <i>eath</i>               | nd Mental H                                       | ygiene 2                           | 008  | 11944   |
|----------------|--|------------------------|--|---|--|--|---|--|---|------------------------------------|--|---|
|                | Physici<br>/Medi   |                        | 1. Decedent's Name (First, Midd<br>Kerry Lee Mi  | - ,   |  |  |   |  | 2. Date of E<br>Month                             |                                    | 08 Year  | 3. Time of Death 8:45pmM                                |
|                | Examir   |                        | 4a. Facility Name (If not institution Anne Arundel   |   |  |  | 4b. City, Town, or<br>Anna                              | Location of polis                      |   |                                    | nty of Death<br>nne Ar                           | undel   |
|                | Funeral<br>Director  |                        | 5. Social Security Nur <b>6491</b><br>157–70–6 <del>492</del>  | 6. Sex<br>1 ☐ M 2X F                                    | 7. Age (In yrs. las<br>43  | st birthday)<br>Yrs.                   | If Under 1 Year<br>Months Days                          | If Under 2<br>Hours                    | 4 Hrs. 8. Date of E<br>Min. 8/24/                 | lirth<br>Day, Year)<br>L 964       | 9. Birthp<br>Coul                                | place (State or Foreign ntry) NJ                        |
|                | Maryland<br>f show<br>led at   | tor                    | Usual Residence of Decedent  10a. State 10b. County  MD Anne   | Arundel   |  | Town or Lo<br>Riva                     | cation  |  |   |                                    |  | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No                   |
|                | with the<br>3a or 28a<br>t be notif  | I Direc                | 10e. Street and Number 2800 Hambleto   | n Pd  |  |  | 10f. Zip Code   | 140                                    |   | 10g. Citizen                       | 7.   | ntry?   |
| 9600-          | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   | ed by Funeral Director | 11. Marital Status  1 Never Married Marital 3 Widowed 4 Divorced   | 12. Was Dece<br>Armed Fo<br>1  Yes<br>If Yes, Giv       | 21 No<br>e<br>ates:  |  |   | spanic Orig<br>n, Mexican,<br>Specify: | in? (Specify Yes or N<br>Puerto Rican, etc.)      | Spe                                | ony.   | etc.<br>ite   |
| 21215-0036     | d within 72<br>giene.<br>er than "na<br>the Medic  | Completed              | (Specify only higher<br>Elementary/Secondary (0-12)  | college (1  |  | (Give<br>life. L                       | kind of work done d<br>DO NOT use retired;<br>pecialist | urina most                             | of working  | F                                  | f Business/In                                    | vernment  |
| Maryland       | 12 should be filed within hand Mental Hygiene.<br>h and Mental Hygiene.<br>7 is marked other than "raumatic event, <u>the Mec</u>  | To Be C                | 17. Father's Name (First, Middle Ed Miller   | Last)   |  |  |   |  | s Name (First, Middle<br>oris Brown               |                                    | name)  |   |
|                | 1 and 2 sho<br>Health and<br>tem 27 is ma  |                        |  | Spouse  |  | 2800                                   | Hambleto:   |  | r or Rural Route Nurr<br>Riva, MI                 | -                                  | wn, State, Zip                                   | Code)   |
| Baltimore,     | permit. Pages 1 and<br>Department of Health<br>Important: if item 27<br>any injury or other tr   |                        | 20a. Method of Disposition  XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3  | Specify)  | State cen  | netery, cřer<br>e <b>mont</b>          | sition (Name of<br>natory or other place<br>Mem Gard    | ens 3                                  |   | Davids                             |  | e, MD   |
| Bal            | permit<br>Depar<br>Impor<br>any in   |                        | 21. Signature of Funeral Services  | all   |  | 12                                     | 2 Ridgely   | Ave.                                   | Hardesty<br>Annapoli                              | s, MD                              |  |   |
| 8760,          | Physician / Medical Examiner and physician and the prinal-transit the prinal-transit the prinal physician and phys | dical Examiner         | 23a. Part1. Enter the sease, os shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (   | or as a consequent or as a conse | nce of):                               | phalopa<br>moniae                                       | thy                                    | Pols  | arrest,                            |  | Approximate<br>Interval Between<br>Onset and Death      |
| O. Box 6       | The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the  | Physician/Medio        | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 № No<br>9 □ Unknown  | 1 ☐ Live b  | come pf pregnanc<br>irth 2 Fetal do<br>ant at time of dear<br>wn   | eath 3                                 | Ectopic pregnancy Other (specify)                       |  |   |                                    | Date of delive                                   | ery<br>Day Year   |
| <b>Q</b>       | quires that<br>in signed by<br>uld be deta   | þ                      | Part II. Other significant conditi   | ons contributing to de                                  | ath but not resultin   | ng in the ur                           | derlying cause give                                     | n in Part I.                           |   | tobacco use co                     |  | ne cause of death?                                      |
| Vital Records, |  | Completed              |  |   |  |  |   |  | 24a. Wa<br>aut<br>per<br>1 Yes                    | opsy<br>formed?                    | b. Were auto<br>prior to co<br>death?<br>1 □ Yes | psy findings available<br>mpletion of cause of<br>2  No |
| or Vit         | Physician:<br>this certific<br>ral director,   | To Be                  | 25. Was case referred to medica examiner? 1 ☑ Yes 2☐ No  | Hospital: 1   | ·  | R/Outpatien                            | t 3 DOA Othe  | r: 4 🗆 Nur                             | of Death <i>(Check only</i> sing Home 5 🗆 Re      |                                    | Other (Specif                                    | y)  |
|                | Attending or death. ector: After by the funer  | Certification:         | 27. Mann Death  1  | gation  | of Injury<br>h, Day Year)<br>of injury - At home<br>ng, etc. (Specify)   | 8b. Time of<br>Injury<br>e, farm, stre |   | at<br>?<br>′es 2∐N                     | o 28f. Location                                   | Street and Nu                      |  | ul Route Number,  |
|                | fospita<br>4 hours<br>funeral<br>ely fille   | edical C               | 29a. Certifier 1 Certifyin (Check only one) 2 Medical  | ng Physician: To the<br>Examiner: On the ba<br>and mann | ısis of examinatioı  | edge, death<br>n and/or inv            | occurred at the tim<br>restigation, in my op            | e, date and<br>pinion, deat            | i place, and due to the<br>h occurred at the time | e cause(s) and<br>e, date and plac | manner as s<br>ce, and due to                    | tated.<br>the cause(s)                                  |
|                | To the h<br>within 2<br>To the l<br>complet  | Me                     | 29b. Signature and title of certific   |   |  | >                                      | 29c. License  |  | a-  | 29d. Date sig                      | ned (Month,                                      | Day, Year)  |
| 1              | Om   | )                      | 30. Name and address of person   | who completed cause                                     | e of death (Item 20)   | A                                      | Print)  | ~ 7<br>285                             | 11 Col Con  | 3/2                                | 5 200<br>Duna                                    | 8 Dolis 2140  |
|                | Sta<br>Registr   |                        | 31. Date filed (Month, Day, Year)  MAR 2   | 7 2008 32. F  | gistrar's Signatur   | K A                                    | books   |  |   |                                    | . 47 14 (6/2                                     | Land City   |

State

Registrar MAR 2 7 2008

Richard Pelmer

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00055120

Suite 310 Washington DC 20032

March 24 200B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Diane Monaghan Rayne 9:19 AM 25 March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 213-22-7740 1 □ M 2 🕱 F Hours 80 Director 3/17/1928 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Fairmont Drive filed within 72 hours after death v Hygiene. other than "natural", or items 238 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ▼No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 secretary insurance other 1 permit. Pages 1 and 2 should be file De artment of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, on o. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Rayne Evelyn Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Fairmont Dr., Bel Air, MD 21014 James P. Monaghan Sr/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 3/31/08 Dennis Family Cemetery Willards, MD 22. Name and Address of Facility
HOLLOWAY Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Lio Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LOCOCCU /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): law requires that the death certificate be exe Physician/Medical attending IE EEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes certificate 2□ No the Hospital or Attending Physician; hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aft To the Funeral D completely filled in 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053568 March 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Cherapeake Dr ceppes 050 W 32. Registrar's Signature 31. Date filed (Month State 8 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|   |  |                               |   |   | Cer                            | tificate                     | of Death                                   | R  | eg. No.          | 10 1                               | 1941                        |
|---|--|-------------------------------|---|---|--------------------------------|------------------------------|--|--|------------------|------------------------------------|-----------------------------|
|   |  |                               | 1. Decedent's Name (First, Middle, Las  | ()  |                                |                              |  | 2. Date of Deat                          | th               |                                    | Time of Death               |
|   | Physici-   |                               | Cora K. H   | owell   |                                |                              |  | Month<br>March 1                         | 9 200            | Year 2                             | 2:45                        |
| 1   | . /Medic<br>Examin   |                               | 4a Fecility Name (If not institution, give  | street and number)                                  |                                |                              | 4b. City, Town, o                          | r Location of Death                      | 4c. County       |                                    | <u> </u>                    |
|   |  |                               | Prince George's   | Hospital  |                                |                              | Chever                                     | ·1v                                      | Pri              | nce Geo                            | rge's                       |
|   | Funeral  |                               | 5. Social Security Number 6. Se   | 7. Age (In y  | s. last birthday)              | If Under 1 Y                 | ear If Under 24 H                          | rs. 8. Date of Birth                     |                  |                                    | (State or Foreign           |
|   | Director   |                               | 229-32-9833   | <sup>□ M</sup> <sup>2</sup> X•XF 79                 | Yrs.                           | Months D                     | ays Hours Mi                               | Feb 4,                                   |                  | Virgi                              |                             |
| 7   | 2 _  | '                             | Usual Residence of Decedent   |   |                                |                              |  |  |                  |                                    |                             |
| op a  | P P  | _                             | 10a. State 10b. County  | 10c.  | City, Town or Lo               | cation                       |  |  |                  |                                    | nside City Limits           |
| 3   | 98   | ç                             | Maryland Prince G   | eorge's Ca  | pitol H                        | eights                       |  |  |                  |                                    | XOYes 2□No                  |
| ŧ   | 6 2 2  | D I                           | 10e. Street end Number  |   |                                | 10f. Zip Co                  | de   | 1  | 0g. Citizen of \ | Whet Country?                      |                             |
| 4   | items 23a or 28a-f show  | ā                             | 621 Capitol Heig  |   |                                | 207                          |  |  |                  | ed Stat                            |                             |
| 9   | itams<br>Der m   | - Ru                          | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?           | U,S. 13. V                     | Vas Decedent<br>Yes, specify | of Hispanic Origin?<br>Cuban, Mexican, Pue | (Specify Yes or No-<br>erto Rican, etc.) |                  | e - American In<br>ck, White, etc. | dian,                       |
| 20  | ö  | Ϋ́                            | 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced  | 1 ☐ Yes 2 ☑ No                                      | 1                              | □Yes 2√2                     | No Specify:                                |  | Specify          | /:                                 |                             |
| 1215-0020   | "natural", or  | Completed by Funeral Director | 15. Decedent's Ed   | Year or Dates:                                      | 16a Dagad                      | ent's Usual O                | acupation.                                 | 1  | 10h Kind of D    | Bla<br>usiness/Industr             |                             |
| 15  | 100  | Set                           | (Specify only highest grad  | fe completed)                                       | (Give                          | kind of work de              | one during most of w<br>etired)            | rorking                                  | TOD. KING OF B   | usiness/mausir                     | ,                           |
| 212   | that a   | E                             | Elementary/Secondary (0-12) 12 years  | College (1-4or 5+)                                  |                                |                              | Escort                                     |  | Covo             | nment                              |                             |
| od 2  | 프형등  | Be C                          | 17. Father's Name (First, Middle, Last)   |   | 56                             | currey                       |  | ame (First, Middle, M                    |                  |                                    |                             |
| <u>a</u>  | marked o   | To B                          | Harvey Lewis  |   |                                |                              | Edith                                      | Kemper                                   |                  |                                    |                             |
| ary   | M pur  |                               | 19a. Informant's Name/Relationship (T   | /pe, Print)   | 19b. Mailin                    | g Address (St                |  | Rural Route Number                       | , City or Town,  | State, Zip Cod                     | e)                          |
| 2 6   | 27 is  |                               | Sheronda Powell -   | Daughter  | 621                            | Capito1                      | Heights                                    | Blvd Capi                                | tol He           | ights,                             | MD 20745                    |
| S S   | item<br>othe   |                               | 20a. Method of Disposition  | 20b   | Place of Dispos                | sition (Name o               | f place)                                   | Date                                     | 20c. Location -  | City or Town,                      | State                       |
| mc  | nt: if   | 1                             | 1 ☐ Burial 2 ☐ Cremetion 3 ☐ I<br>4 ☐ Donation 5 ☐ Other (Specify,  | nemoval nom State                                   |                                |                              |  | Mar 27, 2                                | 008 B            | centwoo                            | d MD                        |
| Baltimore, Maryland 21215-0020  | Department of Health and Menta<br>Important: If item 27 is marked of<br>any injury or other treumatic ev<br>pnce.                      | ŀ                             | 21. Signature of Funeral Service Licens   |   |                                |                              |  | tewart Fu                                |                  |                                    |                             |
| m g   | P F P S  | İ                             | 1 lohy bot  | Till of   |                                |                              |  | , NE Wash                                |                  |                                    |                             |
|   |  |                               | 23a. Part1 Poter the disease, or comp<br>shock or beart failure. List only o  | ications that caused the de                         |                                |                              |  |  |                  |                                    | roximate                    |
| PI  | nysician   |                               | shock or beart failure. List only o   | ne cause on each line.                              |                                |                              |  |  |                  | Inte                               | val Between<br>et and Death |
| ) 1   | Medical  |                               | Immediate Cause (Final disease or condition   | Cardiopulm  | onary A                        | rrest                        |  |  |                  |                                    |                             |
| E   | xaminer  |                               | resulting in death)   | a   | (or as a consequ               |                              |  |  |                  | 1                                  |                             |
| 0   | 45   | edicai Examiner               |   | Cardiac Ar  |                                |                              |  |  |                  |                                    |                             |
| I Records, P.O. Box 68760,<br>The law requires that the death certificete be executed | physician end<br>s the buriel-transit  | E                             | Sequentially list conditions,   | Due to  | (or es a consequ               | uence of):                   |  |  |                  |                                    |                             |
| 80,<br>80,  | cian   | <u> </u>                      | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | . Ischemic H  | eart Di                        | sease                        |  |  |                  |                                    |                             |
| <b>68760,</b> ficete be ex  | the I  | 응                             | that initiated events resulting in death) Last  | Due to  | (or as a consequ               | ence of):                    |  |  |                  |                                    |                             |
| × 6   | ding pl  | ₩                             |   | Diabetes M  | ellitus                        |                              |  |  |                  |                                    |                             |
| P.O. Box<br>at the death cer  | been signed by the ettendir<br>should be detached for use  | by Physician/M                |   |   |                                |                              |  |  |                  |                                    |                             |
| o 🖁   | the check  | ysic                          | Part II. Other significant conditions con   | tributing to death but not re                       | sulting in the un              | derlying cause               | given in Part I.                           | 23b. Did to                              | becco use co     | ntribute to the                    | cause of deeth?             |
| <b>ت</b> . ‡  | ed by<br>detac   | 듄                             | Hypertension, Car   | cinoma Right  | Lung (                         | Rejecte                      | ed),                                       | 1 □ Y€                                   | s 2 No           | 3 ☐ Probably                       | 4€ Unknown                  |
| Records,  | d be   | 5                             |   |   |                                |                              |  | 04- 144                                  |                  | 24h Woro a                         | utopsy findings             |
| S B   | neec   | Completed                     | Hypothyroidism  |   |                                |                              |  | 24a. Was er<br>perform                   | n ed?            | available                          | e prior to                  |
| Je was  | has l  | Ē                             |   |   |                                |                              |  |  |                  | of deeth                           | ion of cause<br>?           |
| <u> </u>  | cate   |                               |   |   |                                |                              |  | 1 □ Ye                                   | s 2 StNo         | 1 ☐ Yes                            | 2□ No                       |
| Vicion V  | recto  | <b>-</b>                      | 25. Was case referred to medical examiner?  | lospital:   |                                |                              | Othor                                      | eath (Check only one                     |                  |                                    |                             |
| o ty  | al di<br>di  | ို                            | 1 ☐ Yes 2∑ No   | 1 □ Inpatient 2L                                    | XER/Outpatient<br>28b. Time of | 3L DOX                       | 4 Li Nursing                               | Home 5 Reside                            |                  |                                    |                             |
| C guil  | After<br>fune  | <u></u>                       | 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)            | Injury                         |                              | njury at<br>Work?<br>I □ Yes 2 □ No        | 28d. Describe 110                        | w injury occurr  | ea                                 |                             |
| ISI at  | deat<br>ctor:<br>y the   | lica                          | 3 Suicide 6 Could not be  | 28e. Place of Injury - At                           | home farm stre                 |                              |  | 28f. Location (Str                       | reat and Numb    | er or Rural Rou                    | te Number                   |
| DIVISION Of VITAI<br>1 or Attending Physicien: T                                      | Oliva<br>Jin b   | Certification:                | 4 ☐ Homicide determined   | building, etc. (Spec                                | ify)                           | et, ractory, on              |  | City or Town                             |                  | or or ribrar ribb                  | te reumber,                 |
| spital  | within 24 hours effer death.  To the Funeral Diractor. After this certificate has completely filled in by the funeral director, page 2 | <u>a</u>                      | 29a Certifier Certifying Phys   | iclan: To the best of my kn                         | owledge, dawth                 | onnumed at its               | official class and obse                    | e and due to the me                      | useful and co-   | ce se ne etato t                   |                             |
| 운   | Fun<br>letely  | edical                        | (Check only 2 Medical Examinations)   | ner: On the basis of examination and manner stated. | ation and/or inve              | estigation, in m             | y opinion, death occ                       | urred at the time, da                    | ite and place, a | and due to the o                   | ause(s)                     |
| To th   | withi<br>To th   | -                             | 29b. Signature and title of certifier   | 4   |                                | 290. Lic                     | ense number                                | 29                                       | d. Date signed   | (Month, Day,                       | Year)                       |
|   |  |                               |   | 1   |                                |                              | -07.6                                      | -522                                     | 2/1              | 2 //                               | 4.05                        |
|   |  | 1                             |   | •   |                                |                              | 0014                                       |  | 77 1             | 1116                               | -}X                         |
|   | $\overline{i}$   |                               | 30. Name and address of person who co   | mpleted cause of deeth (Ite                         | m 23e) (Type, P                |                              | 0024                                       |  | 01.              | 2116                               | 8                           |
| )<br>   | 4)   |                               | 30. Name and address of person who co   |   |                                | rint)                        | Cheverly,                                  | MD 20785                                 | 01.              | 2116                               | F                           |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 25, Jeanne Petty 2008 2:20 P M March /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Arnold 201 Rugby Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🕅 F Hours Director 197-20-9450 81 29,1926 Pennsylvania Nov. Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Anne Arundel Arnold MD Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 201 Rugby Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 4+ marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F Be John Maher Marteas Fehr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 201 Rugby Road Arnold, Maryland 21012 Alan F. Petty/ Husband March 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Impral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 /www 2sa Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🛭 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Division or Vital Records, P.O.

Medical Certification: Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bestgate Rd. Annapolis, Md. 21401 Selouicu 900 MO

Registrar

MAR 2

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 10:00 A M Lannie P. Parks 04 05 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. Williams oustul tospi lake LL at 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Ye. 5/26/1940 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 67 Maryland

**Physician** /Medical Examiner **Funeral** Director a or 28a-f show t be notified at Director "natural", or items 23a odleal Examiner must b Funeral Baltimore, Maryland 21215-0036 \$ Completed the Medical Il Hygiene. Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, I Be P **Physician** /Medical Examiner Examiner n and ial-tran Box 68760. physician buri the as P.O.

The law requires that the death certificate be executed attending |

page 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

GREGORIO

31. Date filed (Month, Day, Year)

Records,

Vital

ō

the Hospital or Attending Physician:

220-36-3643 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland | Dorchester Secretary 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 111 South St. 21664 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 3 ☐ Widowed 4 🛮 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Wholesale Distributor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Logan W. Parks Doris Ruark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanell Todd/Daughter 3411 Cedar <u>Ln., East New Market,MD 21631</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MidShoreCremationCenter 4/6/2008 | Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Sinature of Funer Vivice Licensee Mid Shore Cremation Center PO Box 2272 Hudson Rd., Cambridge, MD 21613 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinome Bile Puets metastel Due to (or as a consequence f) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lue to for as a conseduence of Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 1□ Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 A Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

CHINABERRY DR. SALISBURY, MD

M. BELLOSO, M.D., 5302

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 22, 2008<sup>e</sup> MARCH FRANCES NANETTE RIDENOUR 1350 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21511 EAST COOPERTOWN ROAD TILGHMAN TALBOT If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JUNE 24, 1944 1□ M 2 😿 F Months Days Hours Min. 218-40-6015 63 MARYLAND Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits X∏Yes 2 □ No Director MD. TALBOT TILGHMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 21511 EAST COOPERTOWN ROAD 21671 U.S.A. Pages 1 and 2 should be filed within 72 hours after death w nent of Health and Mental Hygiene. ant; If Item 27 is marked other than "natural", or Items 23s Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify ģ 3X Widowed 4 ☐ Divorced Completed er than "natur ; the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 0 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ev JOHN A. HADDAWAY, SR. NANNIE NEWNAM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 JUDAS STREET, EASTON, MD. Item 27 PATTY ANN MC NEAL/ DAUGHTER 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or of once. 1 ☐ Burial 2 ☐ Removal from State CHES. CREM. CTR. 4 ☐ Donation 5 ☐ Other (Specify) 3/25/2008 STEVENSVILLE, MD. 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. MERCERON JOHN R. 200 S. HARRISON STREET, EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerotic scular disea **Physician** Carreto Va disease or condition resulting in death) VIENTES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Examiner law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the 88 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo 9 ☐ Unknown for Month Dav 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death. Certification: 1 Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

State Registrar

Hospital within 24 hours

4 Homicide

(Check only one) 29b. Signature

29a. Certifier

Medical

1013 S. TALBOT, STE 13, ST MICHAELS, MD 21663 MD

pleted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D006668

|                   |  |                     | State of Maryland / Department of Health and N   | Mental Hy                     | giene         | 90300                    | No. 1 e area tribin e               |
|-------------------|--|---------------------|--|-------------------------------|---------------|--------------------------|-------------------------------------|
|                   |  |                     | 1 - State Registrar Amend#5. Per Informant PGC4-4-08cr Certificate of Death  |                               | Reg. No       | .2008                    | 3   1951                            |
| Н                 | Dhyolei  |                     | 1. Decedent's Name (First, Middle, Last)   | 2. Date of De                 | eath<br>Da    | V Vons                   | 3. Time of Death                    |
| . 4               | Physici<br>/Medic  |                     | Debra Tawana Rollins   | March                         | 21            | 2008                     | 0123a M                             |
| Ç.                | Examir   |                     | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   | 1                             | 4c            | . County of Dea          | th                                  |
|                   |  |                     | Prince George's Community Hospital Cheverly  |                               | Pr            | ince Ge                  |                                     |
|                   | Funeral  |                     | 5. Social Security Number 4846 6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.  | 8. Date of Bir<br>(Month, Da  | ay, Year)     | 9. Bir                   | thplace (State or Foreign ountry)   |
| li.               | Director   |                     | 577-72- <del>1952</del> 55 ***   | July 1                        | 3, 1          | .952 Was                 | hington, DC                         |
|                   | and and  |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                               | -             |                          | 10d. Inside City Limits             |
|                   | Maryl<br>f sho<br>ied a  | ō                   | Manual and During Council During Council   |                               |               |                          | 1 TYes 2 No                         |
|                   | the 28a-   | rec                 | Maryland Prince George's Brentwood  106. Street and Number 10f. Zip Code   |                               | 10a. Cit      | tizen of What Co         | ountry?                             |
|                   | 3a or  | Ö                   | 4142 Bunker Hill Road Apt. 515 20722   |                               | _             | ISA                      | ,                                   |
|                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Uther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at   | by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St  | pecify Yes or No              |               | 14. Race - Ame           | erican Indian,                      |
| ထ                 | after<br>or ite<br>nine  | 臣                   | Armed Forces? If Yes, specify Cuban, Mexican, Puèrti 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:   | o Hican, etc.)                |               | Black, Whit              |                                     |
| 21215-0036        | ral", Exar   | d b                 | 3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates:   |                               |               | Specify:                 | Black                               |
| 5-0               | 72 h<br>'natu<br>dical   | Completed           | 15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)   | kina                          | 16b. K        | ind of Business          | /Industry                           |
| 2                 | /ithin<br>ne.<br>han '<br>e Me   | ם                   | Elementary/Secondary (U-12)   College (1-4or 5+)   | Ü                             | _             |                          |                                     |
| 2                 | lled v<br>Hygie<br>her t   | ပိ                  | 2 Administative Officer  17. Father's Name (First, Middle, Last) 18. Mother's Nam  | o /Eirot Middle               |               |                          | Government                          |
| and               | ntal H<br>ed ot  | Be                  |  |                               |               | ,                        |                                     |
| Ž                 | hould<br>d Me<br>mark<br>matic   | ဥ                   | 19a. Informant's Name/Relationship (Type. Frint)  19b. Mailing Address (Street and Number or Ru  | Dorothy                       |               |                          | 7:- 0-4-)                           |
| Maryland          | d 2 s<br>th an<br>7 Is u   |                     | LaTisa Wilder - Daughter 9500 St. Annes Court,   |                               |               | 20706                    | zip Code)                           |
|                   | Heal<br>Heal<br>tem 2  | 1                   | 20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)   | Date                          |               | ocation - City or        | Town, State                         |
| Baltimore,        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 11 8                | 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Crematory 3/3  | 1 / 2008                      | Bron          | twood                    | Maryland                            |
| ₹                 | artme<br>ortan<br>Injur  |                     | 21. Signature of Fuperal Service Licenses 2  |                               |               |                          |                                     |
| ñ                 | permit<br>Depar<br>Impor<br>any In   | l ,                 | 3401 Bladensburg Rd  |                               |               |                          | 20722                               |
| H                 |  |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac   | or respiratory a              | rrest,        |                          | Approximate                         |
| 8                 | Physician  | 8 7                 | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Gardiac Arrythmias Glassas or condition   |                               |               | 1                        | Interval Between<br>Onset and Death |
|                   | /Medical   |                     | disease or condition resulting in death)  Tactar Sartarac Arry Timeras  Due to (or as a consequence of):   |                               |               |                          |                                     |
|                   | Examiner   |                     | Cognosticilly list conditions  |                               |               |                          |                                     |
| 16                | D :=   | ner                 | Sequentially list conditions, if any, leading to immediate guide. Either Underlying Due to (or as a consequence of):   |                               |               |                          |                                     |
|                   | ecute<br>ind<br>trans  | Examiner            | that initiated events  |                               |               |                          |                                     |
| 30,               | oe execian sian siurial-   | ũ                   | Due to (or as a consequence of):   |                               |               |                          |                                     |
| 68760,            | ficate be executed<br>physician and<br>s the burial-transit  | dical               | d  |                               |               |                          |                                     |
| 9 x               | ding page as   | Me                  | IF FEMALE:   |                               |               |                          |                                     |
| Box               | atten<br>for us  | ian                 | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)   |                               | 10            | 23d. Date of de<br>Month | livery<br>Day Year                  |
| o.                | the de   | Physician/Me        | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)   |                               |               |                          |                                     |
| σ.                | The law requires that the death certifite has been signed by the attending age 2 should be detached for use as   |                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did i                    | tobacco i     | use contribute to        | the cause of death?                 |
| Records, P.       | w requires (<br>been signe<br>should be (  | d by                |  | 10                            | Yes 2         | □No 3□P                  | robably 4XUnknown                   |
| Ö                 | w rec  | lete                |  | 24a. Was                      | an            | 24h Wara a               | utopsy findings available           |
| Be                | he la<br>e has<br>age 2  | Completed           |  | auto<br>perfe                 | psy<br>ormed? | prior to death?          | completion of cause of              |
| ta                |  | ပို                 | 25. Was case referred to medical 26. Flace of Dea  | 1 Yes                         | 2 <b>x</b> No | 1 □Yes                   | 2 □ No                              |
| >                 | ysicia<br>s cer<br>direct  | To B                | examiner? Hospital: Other:   |                               |               | 6 □Other (Spe            | citu)                               |
| Division or Vital | Attending Physician: The r death. ector: After this certificate he by the funeral director, page   |                     | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at  | 28d. Describe                 |               |                          | ony)                                |
| ō                 | ath.<br>rr: Aff  | atio                | 2 Accident investigation M 1 ☐ Yes 2 ☐ No  |                               |               |                          |                                     |
| <u>&gt;</u>       | P C C  | iệ                  | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (<br>City or To | Street ar     | nd Number or R           | ural Route Number,                  |
|                   | tal or   | Certification:      |  | 01.9 01 70                    | m, oluk       | -/                       |                                     |
|                   | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   |                     | 29a. Certifier (Check only  Ch | , and due to the              | cause(s       | ) and manner as          | s stated.                           |
|                   | To the lewithin 24   | Medical             | and manner stated.   |                               |               |                          |                                     |
|                   | No o   | -                   | 29b. Signature and title of certifier  29c. License number   |                               |               | te signed (Moni          |                                     |
| •                 |  |                     | D58957   |                               | Marc          | h 25, 2                  | 8008                                |
| 2                 | (7)  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mark Little, M.D., 3001 Hospital Drive, Cheverly, MD   | 20785                         |               |                          |                                     |
|                   | Sta  | te.                 |  | 20/03                         |               |                          |                                     |
| - 10              | Registr  | _                   | 31. Date filed (Month, Day, Year)  MAR 2 7 2008  32. Registrar's Signature   |                               |               |                          |                                     |

DHMH 17 Rev 1/2001

|                            |  |                | For<br>State<br>Registrar  | State of Maryland  |                        | rtment of<br>tificate of      |  |   | iene<br>g. No. 0 | 08                          | 119                           | 52                   |
|----------------------------|--|----------------|--|--|------------------------|-------------------------------|--|---|------------------|-----------------------------|-------------------------------|----------------------|
|                            |  |                | 1. Decedent's Name (First, Middle, Last)                                   | * *  |                        |                               |  | 2. Date of Deat                             |                  | V                           | 3. Time of                    | Death                |
| П                          | Physicia   |                | JANET RUTH   | H RIEGE  |                        |                               |  | APRIL                                       | <sup>Day</sup> 2 | 0 0 8                       | 5:51                          | РМ                   |
|                            | /Medic<br>Examin   | _              | 4a. Facility Name (If not institution, give st                             |  |                        | 4b. City, Town,               | or Location of Death                       | 1   | 4c. County       | y of Death                  |                               |                      |
|                            | LAGIIIII   | ٠.             | GENESIS LA PLAT  | TA CENTER  |                        | LA P                          | LATA                                       |   | CHA              | RLES                        |                               |                      |
|                            | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1□  | 7. Age (In yrs. Ia                                       | st birthday)<br>Yrs.   | If Under 1 Yea<br>Months Days |  | 8. Date of Birth<br>(Month, Day,<br>AUG • 6 | 1°9′36           | 9. Birthp<br>Court<br>W • V | lace (State or<br>IRGIN       | Foreign<br>IA        |
|                            |  |                | Usual Residence of Decedent  |  |                        |                               |  |   |                  | 1                           |                               |                      |
|                            | yland  |                | 10a. State 10b. County   | 10c. City,   | Town or Lo             | cation                        |  |   |                  | 1                           | 0d. Inside Cit                | •                    |
|                            | Mar.   | io             | MD CHARLES   | LA   | PLAT                   | A                             |  |   |                  |                             | 1 🔀 Yes                       | 2 ∐ No               |
|                            | r 28   | Director       | 10e. Street and Number   |  |                        | 10f. Zip Code                 |  | 10  | og. Citizen of   | What Cour                   | ntry?                         |                      |
|                            | h wit  |                | NUMBER 1 MAGNOL  | IA DRIVE   |                        | 20                            | 646  |   | U.               | S. A                        | •                             |                      |
|                            | deat   | Funeral        | 11. Marital Status   | 2. Was Decedent Ever in U.S<br>Armed Forces?             | i. 13. V               | Vas Decedent of               | Hispanic Origin? (S<br>ban, Mexican, Puerl | pecify Yes or No-                           |                  | ce - Americ                 |                               |                      |
| Q                          | after<br>or its  |                | 1 ☐ Never Married 2€ Married   | 1 □Yes 2 □No<br>If Yes, Give                             |                        | ☐ Yes 2☐ N                    |  |   | Specif           | 4                           |                               |                      |
| <u></u>                    | rai',  | d by           | 3 Widowed 4 Divorced   | Year or Dates:   |                        | X.                            | , open,                                    |   | Specif           | , WH                        | ITE                           |                      |
| 2-0036                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther then "natural", or flems 23a or 28a-f ehow<br>ent, tra Medical Examinar must be notified at | Completed      | 15. Decedent's Educi<br>(Specify only highest grade                        |  | (Give                  |                               | e during most of wor                       |   | 16b. Kind of B   | Business/In                 | dustry                        |                      |
| 2                          | Mithin<br>hen.   | m<br>d         | Elementary/Secondary (0-12)  | College (1-4or 5+)                                       |                        | OO NOT use retii              | rea)                                       |   |                  | 01/17                       |                               |                      |
| 7                          | lled v<br>dygie<br>ther t  |                | 17. Father's Name (First, Middle, Last)                                    |  | HOME                   | MAKER                         | 18 Mother's Nar                            | ne (First, Middle, A                        | AT H             | ~                           |                               |                      |
| ä                          | be d all all   | Be             |  |  |                        |                               |  | ·   |                  |                             |                               |                      |
| Ž                          | should be<br>nd Mental<br>r marked<br>umatic ev  | 욘              | HOMER WHEELER  19a. Informant's Name/Relationship (Typ                     | a Print)   | 19h Mailin             | n Addrose /Stra               | RUTH et and Number or Ru                   | MAXWELL                                     |                  | State Zin                   | Code)                         |                      |
| Maryland 2                 | V 6 7 9 9  |                | DELMER D. RIEGE  |  |                        | •                             | WOOD CT.                                   |   |                  |                             |                               | 1                    |
|                            | 1 and 2<br>Health<br>am 27<br>ther tr  |                | 20a. Method of Disposition   | 20b. Pla   | ace of Dispo           | sition (Name of               | - 55                                       |   | 20c. Location    |                             |                               |                      |
| altimore,                  | 000  |                | 1 Burial 2 ☐ Cremation 3 ☐ Re  | moval from State   | metery, cren           | natory or other p             | APR  |   | unt me           |                             | MD                            |                      |
| 를                          | permit. Pag<br>Department<br>Important:<br>any injury once.  |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License | MD   |                        | . CEMET                       | ann of Families                            |   | HELTE            |                             | •                             |                      |
| Ba                         | permit. Pag<br>Department<br>Important: i<br>any injury o  |                | 21. Signature of 1 uneral Service License                                  | A Str  |                        |                               | RA   | YMOND F                                     |                  |                             |                               |                      |
|                            |  |                | 23a. Part1. Enter the disease, or complic                                  | ations that caused the death.                            |                        |                               | SHINGTON                                   |   |                  | IA,                         | Approximate                   | 9                    |
| ۲                          |  |                | shock, or heart failure. List only one<br>Immediate Cause (Final           | cause on each line.                                      |                        |                               | ID.  | ~   |                  |                             | Onset and [                   | Death o              |
| П                          | Physician /Medical   |                | disease or condition resulting in death)                                   | CILIONO  | ASI                    | OWY.                          | of Das                                     | tto.  |                  | X                           | Mon                           | 147                  |
|                            | Examiner   |                |  | Due to (or as a consequence                              | 2 220                  | (nl)                          | 0  |   |                  |                             | eWin                          | 975                  |
|                            | *  | er             | Sequentially list conditions, if any, leading to immediate                 | Due to (a) as a consequent                               | ence of):              |                               |  |   |                  |                             |                               |                      |
|                            | uted   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events     |  |                        |                               |  |   |                  |                             |                               |                      |
| o,                         | be executed<br>sicien and<br>burial-transit  | Exa            | resulting in death) Last   | Due to (or as a consequent                               | ence of):              |                               |  |   |                  |                             |                               |                      |
| 8760                       | cate be executed<br>obysicien and<br>the burial-transit  | dical          | d.   |  |                        |                               |  |   |                  |                             |                               |                      |
| 9                          | certifica<br>nding ph<br>use as ti   |                | IF FEMALE:   |  |                        |                               |  |   |                  |                             |                               |                      |
| Вох                        | eath certific<br>attending p   | an/I           | 23b. Was decedent pregnant 23  | ic. If yes, outcome of pregnan<br>1 Live birth 2 ☐ Fetal |                        | Ectopic pregnar               | icy  |   |                  | ate of delive               | ,                             | rear                 |
|                            | 0 0  | Physician/Me   | in the past 12 months? 1 🗆 Yes 2 📈 No                                      | 4☐Pregnant at time of dea<br>9☐Unknown                   | ath 5□                 | Other (specify)               |  |   |                  | O. III                      | Su,                           |                      |
| <u>_</u>                   | at the de  | Phy            | 9 Unknown  |  | 1411-45                | 4-4-3                         | Deal                                       | 230 Did tol                                 | pacco use con    | stributo to t               | ha gauga of d                 | loath?               |
| ś                          | The law requires that the<br>ste has been signed by th<br>page 2 should be detache   | þ              | Part II. Other significant conditions cont                                 | inputing to death but not resul                          | iting in the ui        | nderlying cause (             | jiven in Part I.                           | 1   |                  | 3 □ Prot                    |                               | Jnknown              |
| 000                        | w requir<br>been si<br>should  | ted            |  |  |                        |                               |  | 1 □ Ye                                      | 2 14 140         | 3 <u> </u> 1 10t            | Jabiy 4 Lic                   | JIRTOWII             |
| e<br>C                     | iaw<br>ias b   | Completed      |  |  |                        |                               |  | 24a. Was a autops                           | n 24b.           | Were auto                   | psy findings<br>mpletion of c | available<br>ause of |
| <u> </u>                   |  | S              |  |  |                        |                               |  | perform<br>1 Tes                            |                  | death?<br>1 ☐ Yes           | 2 🗆 No                        |                      |
| ita                        | cian:<br>ertific<br>actor,   | Be             | 25. Was case referred to medical examiner?                                 | -0-1   |                        | 1                             |  | ath Check only on                           | e/               |                             |                               |                      |
| =                          | Physical this call direct  | မ              | 1 Tes 252No  |  |                        | I 3 DOA                       |  | dome 5 ☐ Reside                             |                  |                             | <b>(y</b> )                   |                      |
| <u></u>                    | ding Ph<br>h.<br>After thi<br>funeral  | on:            | 27. Manner of Death  1 Natural 5 □ Pending                                 | 28a. Date of Injury<br>(Month, Day Year)                 | 28b. Time of<br>Injury | W                             |  | 28d. Describe ho                            | w injury occu    | irred                       |                               |                      |
| S                          | ttendi<br>death.<br>ctor: A<br>y the fu  | cat            | 2 Accident investigation 3 Suicide 6 Could not be                          | 00 00 00   |                        |                               | ☐ Yes 2 ☐ No                               | OR Leasting /O                              | 1004 and 4/      | has as Our                  | -/ O 1/                       | har                  |
| Division of Vital Records, | l or Atten<br>after deati<br>Director:   | Certification: | 4 ☐ Homicide determined  | 28e. Place of Injury - At hor building, etc. (Specify,   | me, farm, str          | eet, factory, offic           | е  | 28f. Location (St<br>City or Town           |                  | iber or Huri                | ai Houte Num                  | iber,                |
|                            | Hospital 24 hours a Funerei I  |                |  | ician: To the best of my know                            |                        |                               |  |   |                  |                             |                               |                      |
|                            | To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.      | Aedical        | one)   | er: On the basis of examinati                            | on and/or in           |                               |  |   |                  |                             |                               | •1                   |
|                            | To To Con  | Σ              | 29b. Signature and title of certifier                                      | IXAL   | ۸                      | Zac. Lice                     | nse number                                 | 20  | 9d. Date sign    | eu (Month,                  | Day, rear)                    |                      |
| •                          |  |                | Strake   | Mayo   | ~~ W                   |                               | 0200                                       | 1750  | 7                | DV,                         | 00                            |                      |
|                            |  |                | 30 Nagroyand address of person who con                                     | ripleted cause of death (Item                            | ZJa) (Type             | TW.                           | , WA                                       | LDORG                                       | 5-, N            | 20                          | 2000                          | 53                   |
| 578                        | * Sta  | ite            | 31. Date filed (Month. Day, Year)  | 32 Registrar's Signat                                    | ure _                  |                               |  |   |                  |                             |                               |                      |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 8:25 P M March 24, 2008 Peter Greenough Randall 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 557 Beech Drive Calvert Lusby If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**X**M 2□F 64 021-32-2116 February 24,1944 New Hampshire Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland | Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 557 Beech Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Detective / MGSGT Police / USMC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boardman Greenough Randall Mary Elizabeth James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexa Jane Randall / Wife 557 Beech Drive, Lusby, MD 20657 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arlington National Cemetery h⊟Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Arlington, Virginia 04/17/2008 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conon 91 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

certificate be executed

Box 68760,

P.0.

Records,

Division or Vital

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: if item 27 is marked other in any injury or other traumatic event, the any injury or other traumatic event, the second in

**Physician** 

/Medical

**Examiner** 

Funeral

Director

28a-f show must be notified at

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items 23a

"natural", or items edical Examiner m

the Medicai

Maryland 21215-0036

Baltimore,

within 72

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

Certification:

Medical

burial-transi and attending physician the as ō signed by the a has

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

performe

Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28h Time of

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 → No

27. Manner of eath 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

29b. Signature and title of cartified

4 Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

March 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth, MD 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678

10+ State Registrar

after death.

I Director: After do in by the funers After

To the Hospital of within 24 hours af To the Funeral D

filled in by

31. Date filed (Month, Day, Year

32. Registras Signature 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MARTHA SMITH IRENE 19, 2008 March 1601 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2X F Director 578-26-4345 84 1,1923 Clinton, April Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be r 2100 Brooks Drive #218 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Black 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Hatton Mary Irene Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Smith / Son 1505 Asheville Rd. District Heights, Md. 20747 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State HARMONY MEMORIAL PARK 03-27-08 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) 21. Sign tu e of Funeral Service License 22. Name and Address of FacilityPope Funeral Homes, P.A. temmons 5538 Marlboro Pike Forestville, Maryland 20747 X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each time. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9□ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 1 Yes 2 No 28 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 Yes 1 hpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury Hospital or Attendl 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Yea MAR 2 7 2008 DHMH 17 Rev 1/2001



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 Surratts Rd., Clinton, Maryland 20735

|                  | Ter State of N  | laryland / Depa                           | artment of H<br><i>rtificate of L</i>                            |  |  | 200                                    | 8 1195   |  |  |
|------------------|---|---|--|--|--|--|--|--|--|
| cian             | Decedent's Name (First, Middle, Last)  BARBARA KAY SIBLEY   |   |  |  | 2. Date of Death<br>Month                    | Day Yea                                |  |  |  |
| dical<br>iner    | 4a. Facility Name (If not institution, give street and number Memorial 4050ito  | 4   | 4b. City, Town, or East  | $\cap$   | March  | 18 200<br>4c. County of De<br>Talb     |  |  |  |
| al<br>or         | 122-26-8867 <sup>1□ M 2</sup> 🗖 F   | Age (In yrs. last birthday) 76 Yrs.       | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Your 29, 1     | eari i r                               | irthplace (State or For<br>Country)<br>EW JERSEY   |  |  |
| J.               | Usual Residence of Decedent  10a. State  10b. County  | 10c. City, Town or Lo                     | cation   |  |  |  | 10d. Inside City Lin                               |  |  |
| Funeral Director | MD TALBOT  10e. Street and Number   | E   | ASTON<br>10f. Zip Code   |  | 10g  | . Citizen of What (                    |  |  |  |
| ral D            | 29752 DUSTIN AVE.   |   | 21   | 601  |  | 1                                      | USA.   |  |  |
| þ                | 11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Deceder Armed Forces  1 □ Yes 22  If Yes, Give Year or Dates                                 | JNo 1                                     | Vas Decedent of Hi<br>f Yes, specify Cuba<br>□ Yes 2☐XNo         | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>pecify Rican, etc.)     | 14. Race - An<br>Black, Wh<br>Specify: |  |  |  |
| Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-40)  | (Give life, E                             | ent's Usual Occupa<br>kind of work done d<br>OO NOT use retired, | uring most of worl                                   | king   | b. Kind of Busines                     | •  |  |  |
| To Be C          | 17. Father's Name (First, Middle, Last)  OSCAR SCHRADER   |   |  |  | e (First, Middle, Mai                        | den Surname)                           | <u> </u>   |  |  |
| F                | 19a. Informant's Name/Relationship (Type, Print)  |   |  | nd Number or Ru                                      | ral Route Number, C                          | ity or Town, State,                    | . Zip Code)  |  |  |
|                  | GEORGE W. SIBLEY/HUSBAND  20a. Method of Disposition  | 20b. Place of Dispos                      | sition (Name of  |  | EASTON, MI                                   | D 21601  2. Location - City of         | or Town, State                                     |  |  |
|                  | 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)   | CHESAPEAR                                 |  | ION CTR  | 3/20/2008                                    | •                                      |  |  |  |
|                  | 21. Signature of Funeral Service Licensee   | Fi  | Name and Addres<br>LLOWS, H<br>O S. HAR                          | ELFENBEI   | N & NEWNAN                                   | FUNERAL                                | L HOME PA  |  |  |
|                  | 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) | ed the death. Do not enterline.           |  |  | or respiratory arrest,                       |  | Approximate<br>Interval Between<br>Onset and Death |  |  |
| dical Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events  c.  | s a consequence of); s a consequence of); |  |  |  |  |  |  |  |
| Physician/Medi   |   | 2 ☐ Fetal death 3 ☐                       | Ectopic pregnancy<br>Other (specify)                             |  |  | 23d. Date of do                        | elivery<br>Day Year                                |  |  |
| þ                | Part II. Other significant conditions contributing to death   | but not resulting in the un               | derlying cause give  | n in Part I.   | 23e. Did tobac                               |  | to the cause of death                              |  |  |
| Completed        | 24a. Was an autopsy performed? deat   |   |  |  |  |  |  |  |  |
| o Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat  | ient 2 ☐ ER/Outpatient                    | Othor  |  | h (Check only one)                           |  |  |  |  |
|                  | 27. Man r of Death  1 ✓ Natural 5 □ Pending (Month, D. 2 Accident investigation   | ury 28b. Time of                          | 28c. Injury<br>Work  | 4 □ Nursing Ho                                       | me 5 Residence<br>28d. Describe how i        |  | ecify)   |  |  |
| Certification:   | 3 Suicide 6 Could not be determined 28e. Place of in  | jury - At home, farm, streetc. (Specify)  |  |  | 28f. Location (Stree<br>City or Town, S      | t and Number or F<br>tate)             | Rural Route Number,                                |  |  |
| edical (         | 29a. Certifler (Check only one)  1 ► CertifyIng Physician: To the best 2 Medical Examiner: On the basis and manner s  | or examination and/or invi                | occurred at the time<br>estigation, in my op                     | e, date and place,<br>inion, death occur             | and due to the caus<br>red at the time, date | e(s) and manner a<br>and place, and du | as stated.<br>se to the cause(s)                   |  |  |
| M                | 29b. Signature and title of certifier   |   | 29c. License   | number   | 29d.   | Date signed (Mor                       | oth, Day, Year)                                    |  |  |
|                  | V   | - MD                                      | 1-00   | 53255  | 3  | /19/                                   | 2008   |  |  |
|                  | 30. Name and address of person who completed cause of a melinide. Butter 134  | death (Item 23a) (Type, P                 | rint) Are F  | rest   | on mi  | > 216                                  | 55   |  |  |
|                  | 31. Date filed (Month, Day, Year) 32. Repst   | rar's Signature                           | • • •  | 1  | 2.4  |  | _  |  |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Almeda Bennett Smith 25 2008 $\mathbf{P}^{\,\mathsf{M}}$ March 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Spa Creek Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Nov. 23, 1915 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 M 200 578-20-3826 92 Director Maryland Usual Residence of Decedent Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Gambrills 1 ☐ Yes 2 X No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 death with 2333 Maytime Drive 21054 U.S.A. Funeral ural", or items 2 | Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 2 1 ☐ Yes 2 🔀 No Specify: 3€Widowed 4 □ Divorced Year or Dates: Completed item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Printing Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mack Long Bessie Bennett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jadene Payne/great-niece 2333 Maytime Drive Gambrills, Maryland 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 3/29/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat uneral evice Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 1000 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician +(zhime' do menter disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical use as been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown this certificate has been ral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA To the Hospital c. . . . . . . . . . . within 24 hours after death. To the Funeral Director: After thi funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2008

29c. License number

032036

D. Bout Drive Choster Mod 2/4/9

29d. Date signed (Month, Day, Year)

3/26/2008

| Decederate Name Grief, Models, Last)   Decederate Name Grief, Models, Last)   Decederate Name Grief, Models, Last)   Decederate Name Grief, Models, Last)   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Models, Last   Decederate Name Grief, Name Grief, Models, Last   Decederate Name Grief, Name Grie   |
|--|
| PAULINE LUCILLE STACK  APRIL 5 2008 10  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  CENTSTS CENTER WALDORF  Server WALDORF  Server WALDORF  CHARLES  Social Security Number (if not institution, give street and number)  Server WALDORF  Tos. State 1 10b. County  Tos. State 1 |
| A FACILITE STACK  A FACILITY AND COLORS AND CONTROL OF THE PROPERTY OF THE PRO |
| FUNCYAL Director  FUNCYAL DIRECTOR  FUNCYAL DIRE |
| Social Security Number    Social Security Number   Social Security Numb |
| Director    Director   |
| Usual Residence of Decedent   10c. City, Town or Location   10d. Inside   10c. City   10   |
| STEPHEN VALENTINE LESHO  STEPHEN VALENTINE LESHO  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type. Print)  19a. Informant's Name/Relationship (Type. Pr |
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| Physician //Medical Examiner  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |
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| Physician /Medical Examiner    Description   Physician |
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| 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 9 Unknown 23c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. If yes, outcome pf pregnancy 1 Unknown 25c. |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause  |
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| OLD CEREBLOVASCULAL ACC DENT 24a. Was an autopsy finding prior to completion   |
| DIABETES DEMENTA  24a. Was an autopsy finding prior to completion death?  1 Yes 2000   |
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| 27. Manner of Death 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year) 1 Nonatural 5 Pending (Month, Day Year)  |
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| Second   S   |
| 29b. Signature and the of captifier 29c. License number 29d. Date signed (Month, Day, Yea  |
| D. 44436 April 07, 2   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |
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| ASHVINKUMAR I PATEL 102 PAULME NON CT WALDORF MD 2   |
| 30. Name and adjress of person who completed cause of death (nem 23e) (Type, Philip  A S H V I K L MAR J PATEL 102 PAUL Me Non CT WALDORF MD 2  State Registrar  Registrar  Registrar  |

State Registrar 31. Date filed (Month, Day, Year) APR11 2008

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)



0035106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry Snyder 1705 26,2008 March /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Rehab + Nursing Ctr Salisbury If Under 1 Year | If Under 24 Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age W vrs. last birthday) 1**⊈**M 2□ F Days Hours 196-14-8606 Director 94 9/6/1913 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Maryland Wicomico 1 Yes 2 □ No Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1374es 2 □ No If Yes, Give Year or Dates.Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 TX Married 3altimore, Mafyland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Poultry Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Luther Snyder Harriett Jefferies ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy J. Gray/daughter 1015 Emmanuel Church Rd., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Juniata Memorial Park 3/29/08 Juniata, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Holloway Funeral Home Professional Association West 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ean-/Medical Du to (or as a consequenc of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a a consequence of): Due to for Examiner certificate be executed and Due to (or as a consequence of): as the burial-Box 68760. attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy , page , this certificate 1∐ Yes 1 ☐ Yes 2 ☐ No 2 4 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N6 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 81 William H. Robins, M.D. 200 ( VIVIC

State

Registrar

32. Registrar's Signature

8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** RICHARD PERRIN MARCH SAVILLE 29, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner WESTERN MARYLAND HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs WV 07-25-1940 67 Director 212-38-6414 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Medical Examiner must be notified at 1√Yes 2 No Director 28a-f MD ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 3 US 21502 34 DELAWARE AVE Funeral 14. Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: WHITE 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) the TRUCK DRIVER TRANSPORTATION 12 marked other injury or other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve RONALD CLINTON SAVILLE HELEN M. RUSCHEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14805 UHC HIGHWAY SE, CUMBERLAND MD 21502 THOMAS CAMPBELL Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 ☐Removal from State MORGANTOWN WV 26506 WVU MEMORIAL VAULT 4-10-2008 4X onation 5 ☐ Other (Specify) 22. Name and Address of Facility
WVU HUMAN GFFT REGISTRY
MORGANTOWN WV 26506 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) udminant Physician /Medical Due to (or as a consequence of): Examiner 1800 Mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-trans Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

P.O. Box 68760, División or Vital Records, ö

hours after death within 24 hours at To the Funeral E Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 SETON DR. Cumberland, MD 21562 MADHUSUDHKN, TARIGOPULA

31. Date filed (Month, Day, Year)

1 2008 APR 1

29b. Signature and title of certifier

32. Registrar's Signature

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH **Physician** 11:40 A M 2008 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSITAL LANHAM DETORS If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 213-38-0770 1 1 2 M 2 □ F Director 6/1940 414 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 'natural', or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Opertment of Health and Mental Hyghens. Interpreted the Titlem 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any InJury or other traumatic event, the Medical Examiner must be notified at ARROLFON 1 Yes 2 No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 6602 20784 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 Serves 2 No 1963
If Yes, Give
Year or Dates: 1965 Black, White, etc 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 3 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DELIVERY RIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ EARL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TiBBS WIFE NEW CARROLTON Md. 20784 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State FREE CLINES Broist CH 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANOXIC **Physician** exception of hns disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
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1 ☐ Yes Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Impatient 2 ER/Outpatient 3 DOA Certification: To To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 mo YMARUL IS 32. Registrar's Signat 31. Date filed (Month, Day, Year) State MAR 2 7 2008 Registrar

Division of Vital within 24 hours at To the Funeral L

State Registrar

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who completed cause of death (Item 23a)

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Deputy Chief Medical Examiner

determined

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29b. Signature and title of certifications and title of certifications are sent as a second control of the certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and title of certifications are sent as a second certification and the second certification are sent as a second certification and the second certification and the second certification are sent as a second certification and the second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and the second certification are second certification and certification are second certification and certification are second certification and certification are second certification are second certification are second certification and certification are second certification are second certification are second certification are second certifi

30. Name and address of person

APR 0 8 2008

Jack Titus MD.

March 27, 2008

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

3altimore, Maryland 21215-0036

physician and the burial-transit signed by the attending p cate has been signated by this funeral To the Hospital or Attending Pl within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral

Physician/Medical

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Completed

Be

Certification:

Medical

State Registrar 31. Date filed (Month, Day, Year)

P.O. Box 68760,

Division or Vital Records,

IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 10 C 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autonsy 2 1No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature nd title of certife 00660301 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Michael E. Piemer, M.D. 122 Speer Rd. Chestertown, MD. 21620

DHMH 17 Rev 1/2001

32. Registrar's Signature

|                            |   |                                     | 1 - For State Registrar  | State of Ma  | aryland / Dep<br><i>Ce</i>                             | artment of F   |  | Mental Hy  | giene<br>Reg. No. 0 0   | 8 11964  |
|----------------------------|---|-------------------------------------|--|--|--|--|--|--|---|--|
|                            | Physici<br>/Medic   |                                     | 1. Decedent's Name (First, Middle, La<br>RUFEEN  | WI   | LSON   |  |  | 2. Date of De Month  |   | 3. Time of Death                                     |
|                            | Examir  |                                     | 4a. Facility Name (If not institution, giv<br>Fort Washington R<br>5. Social Security Number 6. S  | ehab. Çent   | e (In yrs. last birthday                               | 4b. City, Town, o  Fort Wa  If Under 1 Year  Months Days   |  | ath  S. 8. Date of Bir   | v. Yearl  | E GEORGE   |
|                            | Director  |                                     | Usual Residence of Decedent  10a. State  10b. County   | UM 21/21F  | 78 Yrs.  |  |  | 64/29  | <i>3  929</i>   E]  | 10d. Inside City Limits                              |
| Maryland 21215-0036        | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "naturat, or ttems 23s or 28s-f show raumatic event, the Medical Examble for usible natified at | To Be Completed by Funeral Director | DC  10e. Street and Number  602 Galveston Str  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E. (Specify only highest gra  Elementary/Secondary (0·12)  12  17. Father's Name (First, Middle, Last, Manny Whaley  19a. Informant's Name/Relationship (         | 12. Was Decedent Amed Forces?  1  Yes 2451 If Yes, Give Year or Dates:  ducation  College (1-4or 5 | i+)  16a. Dece (Give life.  Mast                       | Was Decedent of Hif Yes, specify Cuba 1 Yes Son No Indent's Usual Occups kind of work done DO NOT use retired to the Address (Street | Specify:  ation during most of w  18. Mother's N  Hattie and Number or w | (Specify Yes or No<br>erro Rican, etc.)  vorking  lame (First, Middle  Robinso  Rural Route Numb | Black, V Specify:  16b. Kind of Busine Private , Maiden Surmarne) n er, City or Town, Sta | ates American Indian, Vhite, etc. Black ess/Industry |
| Baltimore, N               | permit. Pages 1 and 2 should<br>Department of Health and Mer<br>Important: If Item 27 is marks<br>any injury or other traumattc<br><u>once</u> .  |                                     | Willa Williams / 20a. Method of Disposition  1 Aburial 2 Cremation 3 4 Donation 5 Other (Specification 2). Signature of Tuneral Service Licer  | Removal from State   | 20b. Place of Disp cemetery, cre Resurrect             | osition (Name of<br>matory or other place<br>ion<br>2. Name and Addre  | 3/2  | Date<br>29/2008<br>Ope Funer   | ngton, Md<br>20c. Location · City<br>Clinton,<br>al homes,<br>ille, Md.                   | or Town, State  Maryland  P.A.                       |
| 8760,                      | whysician and worded white burial-transit   | dical Examiner                      | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as b. Due to (or as c.   | a consequence of):                                     | Feile  | ng, such as card   | iac or respiratory a   | rrest,  | Approximate Interval Between Onset and Death         |
| .O. Box 6                  | death certific<br>e attending p<br>d for use as   | Physician/Med                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown                                 | 2 Fetal death 3  | □Ectopic pregnancy □ Other (specify)   |  |  | 23d. Date of<br>Month   | delivery<br>Day Year                                 |
| Δ.                         | requires the<br>been signed<br>should be de   | by                                  | Part II. Other significant conditions of   | Lia  | ut not resulting in the u                              | , -  | en in Part I.  |  | Yes 2□No 3□   | e autopsy findings available                         |
| Vital Re                   | The<br>ate h<br>page  | Be Completed                        | 25. Was case referred to medical examiner?   | Hospital:  | 3 / 63 * ( )   |  |  | auto<br>perfo<br>1 Ves   | psy prior deat 1 □  | to completion of cause of<br>h?<br>Yes 2図No          |
| Division of Vital Records, | or Attending<br>after death.<br>Diractor: After<br>in by the fune   | Certification; To                   | 27. Manner of Death    Matural   5   Pending     Accident   3   Suicide   4   Homicide   Death   | 28a. Date of Injui<br>(Month, Day  | y Year) Injury ury - At home, farm, st                 | of 28c. Injun<br>Wor<br>M 1  | y at   | 28d. Describe  | dence 6 Other (show injury occurred  Street and Number own, State)                        | Specify)<br>r Rural Route Number,                    |
|                            | To the Hospital within 24 hours a To the Funeral Completely filled  | Medical C                           | (Check only 2 Medical Exam   | ysician: To the best on<br>niner: On the basis of<br>and manner sta                                | of my knowledge, dea<br>examination and/or in<br>ated. | vestigation, in my o   | pinion, death oc   | ce, and due to the<br>curred at the time,  | date and place, and   | due to the cause(s)                                  |
| 0                          | To with   | 2                                   | 29b. Signature and title of certifier  30. Name and address of person who  | completed cause of de  | eath (Item 23a) (Type                                  |  | 955  |  | 29d. Date signed (M   |  |
|                            | Sta<br>Registr  |                                     | Edger Potter MD 31 Date filed (Month, Day, Year) MAR 2 7 2008  | 328 South  | ern Ave. S   | .E. Washi  | ngton,   | D.C. 200   | 32  |  |

DHMH 17 Rev 1/2001

| 08-022   | 64 |      |
|----------|----|------|
| Chieless | ۸  | 141: |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

5

| miney Ann vvii   | J              | 1- For State State of Maryland / Department of Health and Menta Certificate of Death  |   | Reg. No. 201   | 08 1196   |
|--|----------------|---|---|--|---|
| Physici  |                | Decedent's Name (First, Middle, Last)   | 2. Date of De                                 | eath<br>Day Year   | 3. Time of Death                                    |
| Medical Exami  | ner            | Shirley Ann Wingfield  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of I   | March 2                                       | 2, 2008<br>4c. County of Dear                                | 0708 hrs  |
|  |                | Prince George's Hospital Center Cheverly  | Death   | Prince Georg   |   |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 579-54-4692 1 M 2 XF 68 Yrs. Months Days Hours   | 24Hrs. 8. Date of Min. Sept                   | Birth (MM/DD/YYYY) 9. B<br>Fore 30, 1939 C                   | irthplace (State or<br>ign Washington<br>ountry) DC |
| any  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |   |  | 10d. Inside City Limits                             |
| <b>*</b>   | F              |   |   |  | 1 X Yes 2 No  |
| Aaryland<br>28n-f show<br>1 at once.   | Director       | 10e. Street and Number 10f. Zip Code  |   | 10g. Citizen of What Co                                      | untry?  |
| ith the Maryland<br>23a or 28a-f sho<br>notified at once.  |                |   |   | United St  | ates  |
| ms pe  | Funeral        | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Forces? 1 Yes 2 No 1 Yes |   | White, etc.  | rican Indian, Black,  Black                         |
| urs aft<br>tural"<br>amine   | d by           | or Dates:   | nd of work done                               | Specify:<br>16b. Kind of Business                            |   |
| 7 3  | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT us  12 years Cook   | se retired)                                   | Governm  |   |
| 21215-0036 ould be filed within 7 I Mental Hygiene. Is marked other than ic event, the Medica  | Be Col         |   | Name (First, Middle<br>trice Pla              | e, Maiden Sumame)  |   |
| D 2121<br>should be fi<br>and Mental I<br>7 is marked  | To E           | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number  | er or Rural Route N                           | umber, City or Town, Stat                                    |   |
| <b>∑</b> 5 d d Z <b>∑</b>  |                | Carl D. Wingfield - Son   1211 Canvasback Co  |   |  |   |
| Baltimore, MD 2 bernit. Pages I and 2 shoul Department of Health and I Important: If item 27 is re nijury or other traumatic   |                | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date  | 20c. Location - City o                                       |   |
|  |                | A Donation 5 Other Specify: Harmony Mem. Park M Signature of Funeral Service Live ex 22. Name and Address of Facility   |   | 008 Landove  |   |
| Balt<br>permit.<br>Depart<br>Import<br>injury  |                | 4001 Benning R  |   |  |   |
| Physician  |                | 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care failude. List only one cause on each line.  | diac or respiratory a                         | arrest, shock, or heart                                      | Approximate Interval Between Onset and              |
| /Medical<br>xaminer  | Ì              | Immediate Cause (Final disease or condition resulting in death)  a. Head Injury with Complications  Due to (or as a consequence of):  |   |  | Death   |
|  |                | Sequentially list conditions,  b  |   |  |   |
|  | Examiner       | if any, leading to immediate  Cause. Enter thicknown Cause  Clisease or injury that initiated  C  |   |  |   |
| cuted<br>and<br>transit  |                | events resulting in death) Last  Due to (or as a consequence of):  d.   |   |  |   |
| 18760,<br>rificate be executed<br>ing physician and  | Medical        | UNPENDED AMENDED  |   |  |   |
| 876(<br>Inficate   |                | IF FEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   2   2   2   2   2   2   2   2   2  | regnancy                                      | 23d. Date of delive<br>Month                                 | ry<br>Day Year                                      |
| Box 687 e death cerrific the attending p   | Physician/     | past 12 months?  4 Pregnant at time of death 5 Other (Specify)  |   | La vi  | 700   |
| D.O. BOX<br>that the death<br>ned by the att   | Phy            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part   | 1 23e Did                                     | tobacco use contribute to                                    | the cause of death?                                 |
| , P.O.   | <u>S</u>       |   |   | 'es 2 ✓ No 3 Pro   |   |
| rds, requir  | Completed      |   | 24a. Wa                                       |  | utopsy findings available completion of cause of    |
| ecc<br>The lav<br>ate has  | g Ho           |   |   | formed? death?   |   |
| Vital Rec<br>ysician: The<br>his certificate<br>director, page   | B C            | 25. Was case referred to medical examiner?  |   |  |   |
| f Vit  | 6              | 1 ✓ Yes 2 No Trospital 1 Inpatient 2 ✓ ER/Outpatient 3 DOA  | Nursing Home 5                                | Residence 6 Other  | er:   |
| Division of Vital Records, lal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be   | Certification: | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 1942 hrs  1 Yes 2 N  | Pedestriar                                    | e how injury occurred<br>n struck by auto                    |   |
| Divis Hospital or A 24 hours after Funeral Dire  | ertific        | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street  | or Town                                       | (Street and Number or R<br>, State)<br>sota Ave., Washingtor |   |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the att inding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical C      | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)   | e, and due to the ca<br>rred at the time, dat | use(s) and manner as sta<br>te and place, and due to t       | ited.<br>he cause(s)                                |
| F. 8 F. 8  | ₽              | 29b. Signature and title of pertifier 29c. License number   |   | 29d. Date signed (Me   | onth, Day, Year)                                    |
| OCME   |                | O.C.M.E.  |   | March 23, 2008   |   |
| R (3)  |                | 30. Name and add ss of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimor   | re, MD 21201                                  |  |   |
|  |                | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | -   |  |   |
| Regist   | rar            | MAR 2 7 2008 Reserve  |   |  |   |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 15:20 PM James Edward Wood Sr. March 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Nov 24 1943 217-44-8246 1 M 2 F 64 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland Calvert 1 ☐ Yes 2 ☐ No Director Prince Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5755 Sixes Road 20678 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No white 3altimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) project Engineer Calvert County Gov. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Edward Whitfield Be Juanita Hardestv 19a. Informant's Name/Relationship (Type. Print)
Sylvia B. Wood -wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5755 Sixes Rd. Prince Frederick, MD 20678 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Asbury Cemetery April 2 2008 Barstow Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myorandia /Medical Due to (or as a consequence of): Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown ate nas been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 3 DOA 2 ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 monompleted cause of death (Item 23a) (Type, Print)
110 Hospital Drive Suite 310 Prince Frederick MD 20678 30. None and address of person

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registras Signature

2008

MAR 3 1

Certificate of Death

2. Date of Death Month

2008

WICOMICO

14. Race - American Indian

Black White etc.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

Specify

3. Time of Death

2:50

10d. Inside City Limits

1 Nes 2 No

Birthplace (State or Foreign Country)

Maryland

white

Decedent's Name (First, Middle, Last)

Weber

Doris

**Physician** 

29d. Date signed (Month, Day, Year) Maly 4 Wourde D 32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 504 B Salis BAUY MD 21804. 106 MITTER WIDDNDILA MAHETH 32. Pogistrar's Signature State Ken Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AVVERAHALLI

APR 1 4 2008

OLD COVET ROAD

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** David 2008 William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 2M 2 F 55 213-62-3317 DECEMBER 25.1952 WEST VIRGINIQ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Parkville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 3000 Moreland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WILIGM HSbUry Baltimore, Maryland 21215-0636 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wire manufacturing Company Manager 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Payne Frank Asbury 2 Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marilyn Asbury wife Parkville, MD 21234 3000 Moreland Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 10,7008 Hanover , MD Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funer ervice Licensee 1522 Connelley Drive Suite P. Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 Live birth 2 Fetal death 4 Pregnant at time of death Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 → Yo Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D0065094 419/08 30. Name and address of person who con DRBinh guare Hospital 000 Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  | -                 | State of Maryland / Department  State of Maryland / Department  Certificate  Certificate   | t of Health and M<br>e of Death                            | lental Hygier                                    | 2000                                      | 11970   |
|----------------------------|--|-------------------|--|--|--|---|---|
|                            |  |                   | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death                                 |   | 3. Time of Death                              |
|                            | Physicia<br>/Medic   |                   | George Poole Allison   |  | April 10   | Day 2008 2                                | 6:50 a м                                      |
|                            | Examin   |                   | Ta: I don't y Trains (it from the control of the co | Town, or Location of Death<br>WSON                         |  | 4c. County of Death<br>Baltimore          |   |
|                            | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months 7. Age (In yrs. last birthday) Months  | 1 Year If Under 24 Hrs. Days Hours Min.                    | 8. Date of Birth<br>(Month, Day, Ye<br>Feb. 18 1 | ar) Coui                                  | place (State or Foreign<br>ontry)<br>Shington |
|                            | p ,  | -                 | Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location  |  |  |   | 10d. Inside City Limits                       |
|                            | shov   | 5                 | Md. Baltimore Towson   |  |  |   | 1 ☐ Yes 2X No                                 |
|                            | 28e-1  | Director          | 10e, Street and Number 10f. Zip  | Code   | 10g.   | Citizen of What Cou                       | ntry?   |
|                            | h with   | i D               | 615 Chestnut Ave.  | 21204  |  | USA                                       |   |
|                            | ems 2  | Funerai           | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Deced   | ent of Hispanic Origin? (Sp<br>ify Cuban, Mexican, Pueno   | ecify Yes or No-<br>Rican, etc.)                 | 14. Race - Ameri<br>Black, White,         |   |
| 36                         | filed within 72 hours after death with the Maryland Hygiene. Hygiene. Steel show then 'naturel', or Items 23s or 28e-f show ent, the Madical Examiner must be notified at  | by Fu             | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ Widowed 4 ☐ Divorced Year or Dates:  |  |  | Specify: W                                | hite  |
| 5-0036                     | turel'   | ed b              | 15 Decedent's Education 16a Decedent's Usua  | Occupation   | . 16b  | . Kind of Business/Ir                     |   |
| 215                        | hin 72<br>9.<br>M. di  | Completed         | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Give kind of wor life. DO NOT us  | k done during most of work<br>se retired)                  | ing  |   |   |
| 7                          | ed wit<br>ygjene<br>yer th   | Con               | +4 Engineer  | 10. Mathada Nam  | e (First, Middle, Maid                           | Engineeri                                 | ng  |
| Maryland 2121              | Ibe fill hall Hall Hall Hall Hall Hall Hall Ha   | Be                | 17. Father's Name (First, Middle, Last) Walter Selwin Allison  |  |  |   |   |
| <u> </u>                   | should<br>nd Mer<br>mark<br>matic  | ၉                 |  | (Street and Number or Run                                  |  |   | o Code)                                       |
| Σ<br>S                     | nd 2 salth ar 27 is 27 is r treu   | 1                 | Mr. G. Burgess Allison/ Son 8301 West  | chester Dr.  | Vienna, Va                                       | a. 22182                                  |   |
| Jre,                       | es 1 a of Hez I tam  | 1                 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State   | ther place)  |  | c. Location - City or T                   |   |
| Ĕ                          | Pagiment<br>ment<br>tent: I  |                   | `4 □Donation 5 □Other (Specify) H1 I I top Servic  |  |  | Towson,                                   | Md.   |
| Baltimore,                 | permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If final 21 is marked other than "naturel, or items 23a or 28e-1 show any injury or other treumatic event, If a Marical Examinet must be nutified at once. |                   | 21. Signature of Funeral Gervice Licensee 22. Name and RUCK 1050   | d Address of Facility<br>Towson Fune<br>York Rd. To        | ral Home,<br>wson, Md.                           | Inc.<br>21204                             |   |
|                            |  |                   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  | e of dying, such as cardiac                                | or respiratory arrest,                           |   | Approximate Interval Between Onset and Death  |
| 7                          | Pnysician  |                   | Immediate Cause (Final disease or condition resulting in death)  a. Congletic HE   | art Sar  | Luce   |   | years   |
| ı                          | /Medical<br>Examiner   |                   | Due to (or consequence of):  |  |  |   | 0   |
|                            |  | e                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |  |   |   |
| 7.                         | outed<br>id<br>ransit  | Examiner          | that initiated events c.   |  |  |   | /   |
| Ö,                         | e exection articles  | Exa               | resulting in death) Last Due to (or as a consequence of):  |  |  |   |   |
| 8760,                      | icate be executed<br>physician and<br>s the burial-transit   | dica              | d  |  |  |   |   |
| 9 X                        | certifii<br>nding I<br>se as   | /Me               | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  |  |  | 23d. Date of deliv                        | very  |
| Box                        | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Medical | in the past 12 months?  1 Yes 2 No   |  |  | Month                                     | Day Year                                      |
| <u>Ф</u><br>О              | d by the   | Phy               | 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting in the ynderlying contributing to death but not resulting to death | ause given in Part I                                       | 23e. Did tobac                                   | co use contribute to                      | the cause of death?                           |
| ds,                        | signed<br>d be del   | d by              | renal failure AtriA  | -  | 1 ☐ Yes  | 2 3 No 3 □ Pro                            | bably 4 Unknown                               |
| COL                        | w require<br>been si<br>should I   | Completed         | f. Lealingtion   |  | 24a. Was an                                      | 24b. Were aut                             | opsy findings available                       |
| Be                         | The law<br>te has<br>age 2 :   | dwo               |  |  | autopsy<br>performed<br>1 ☐ Yes 2 ☑              | death?                                    | ompletion of cause of<br>2□ No                |
| ita                        | ien: J   | Be C              | 25. Was case referred to medical examiner?   | 26. Place of Dea   | th (Check only one)                              | 1   |   |
| × ×                        | Physicien:<br>r this certific<br>ral director.   | P                 | 1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DC  |  | ome 5 Residenc                                   |   | ify)  |
| ou c                       | ding P   | :lon:             | 1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury  | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                  | 28d. Describe how                                | injury occurred                           |   |
| Division of Vital Records, | Attendiler death.  | ertification;     | 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)  | y, office  | 28f. Location (Stree<br>City or Town, S          | et and Number or Ru                       | ral Route Number,                             |
| ā                          | tal or A   | O                 | 4   Aomicide Building, etc. (Specify)  |  | ony or rown, c                                   |   |   |
|                            | To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page   | edicai            | 29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred and manner stated.   | at the time, date and place,<br>in my opinion, death occu- | , and due to the caus<br>rred at the time, date  | se(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                    |
|                            | To the within To the comp  | M                 | 250. Signature and title Systematic  | c. License number  |  | Date signed (Month                        |   |
|                            | 25   |                   | 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)   | Charles Si   | t. frati   | to Md                                     | 21204   |
|                            | Sta<br>Regist  |                   | 31. Date filed (Month, Day, Year)  APR 14 2008  31. Registrar's Signature  |  |  |   |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me 9878,94411/08dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month APRIL Day [2] **Physician** 08:50FM 2008 Catherine Anna Blair /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 € F 01/03/1919 Maryland Director 89 217-50-3501 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Harford MD Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 U.S.A. 1005 Rosemont Drive Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Catherine Fritsche George J. Diller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> Mary T. Mullen (daughter)</u> 1005 Rosemont Drive - Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/07/2008 | Baltimore, Maryland 4 Donation 5 Other (Specify) Most Holy Redeemer 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS LEFT SUBDORAL HEMATOMA **Physician** LARGE /Medical Due to (or as a consequence of): Examiner WITH BILATERAL UNCAL HERNIATION ON APPROVED BY MEDICAL EXAMPLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit CERTIFICAT Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No certificate has 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 03/30/2008 Unknown 1- Natural 5 ☐ Pending investigation Subject fell. 1 ☐ Yes 2X No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1005 Rosemont Dr. 3 Suicide completely filled in by determined 4 ☐ Homicide Home \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D25586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND 21204 D. 7601 CEBALLOS. M. D. 7601 ( 32 Registrar's Signature ILIA 31. Date filed (Month, Day, Year) State APR 1 4.2008 Registrar

P.O. Box 68760, death certificate be Division or Vital Records, peen has this certificate uneral After death.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008<sup>Year</sup> Day Michele Bianco 15:15 pM April 11, 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year April 1, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 1X M 2□ F 297-38-5408 Italy Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show at OH Mahoning Youngstown ns 23a or 28a-f sh must be notified 1 ☐ Yes 2√€ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 44512 117 Mayflower Drive USA 'natural", or items 23a Funeral death y 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Examiner Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heatilth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Inlury or other traumatic event, the Medical Examiner 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: <u>Ş</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baker Bakery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maddalena Giuliano Angelo Bianco 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lip Code) Maddalena Amero / Daughter 693 Saddlebrook Drive, Youngstown, OH 44512 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Green Haven Memorial April 16,2008 Canfield, OH 4 ☐ Donation 5 ☐ Other (Specify) Gardens \_\_\_\_\_\_ 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 Mou ushal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 days disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Aortic Stenosis Critical 1 year Sequentially list conditions, if or y leading to first and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Coronary Artery Disease 30 years attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 20 years Cardiomyopathy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year signed by the at 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes 1 Yes 2X No 3 Probably 4 Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No P 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 Pending Injury To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) April 14, 2008 29b. Signature and title of certifier P20965 Weela 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neeraja Boddu, St. Agnes Hospital, 900 Caton Avenue, Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                | 1 - State of Maryland / Department of Health and Certificate of Death  | Reg. No. 2008 11973  |
|---|----------------|--|--|
| Physic<br>/Medi   |                | Decedent's Name (First, Middle, Last)  Raymond Thomas Brown  | 2. Date of Death  Month RIL Dayl, SYMAN 08:07AM  |
| Exami   |                | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Deal   | th dc. County of Death Baltimore   |
| Funeral<br>Director   |                | 5. Social Security Number 219-26-8385  6. Sex 1  |  |
| Maryland<br>f show<br>ied at  | ō              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimore  | 10d. Inside City Limits 1X☐Yes 2☐No  |
| n with the<br>3a or 28a-<br>st be notif   | al Director    | 10e. Street and Number  3006 Howard Park Avonue  | 10g. Citizen of What Country?  |
| ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Some New Yes, Specify Cuban, Mexican, Puer 1 □ Yes 2 ☑ No Specify: | Specify Yes or No- rio Rican, etc.)  14. Race - American Indian, Black, White, etc. Specify:  Black            |
| within 72 hou iene. than "naturathe Medical E   | Completed      | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 Years  16a. Decedent's Usual Occupation (Give kind of work done during most of wo  | Lyondell Chemicals   |
| 2 should be filed wi<br>and Mental Hygien<br>is marked other th<br>aumatic event, the   | Be             | 17. Father's Name ( <i>First, Middle, Last</i> )  18. Mother's Name ( <i>First, Middle, Last</i> )   | me (First, Middle, Maiden Surname)   |
| 2 should<br>and Mei<br>is mark<br>aumatic   | 2              | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or R   | Immervilla<br>Bural Route Number, City or Town, State, Zip Code) 21207   |
| jes 1 and 2<br>of Health<br>If item 27 i  |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date 20c. Location - City or Town, State   |
| t. P.c.<br>tant<br>tant   |                | 4☐Donation 5☐Other (Specify) Crownsville Vet. Cem.   | 4/18/08<br>Crownsville, Marylan<br>natman-Harris Funeral Home  |
| permi<br>Depar<br>Impol<br>any Ir   |                | 4210 Belair Roa  | d Baltimore, Md 21206  |
| Physician   |                | 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition   | ac or respiratory arrest, Approximate Interval Between Onset and Death   |
| /Medical<br>Examiner  |                | Due to (or as a consequence of): Sequentially list conditions  b.  |  |
| ag W igi  | Examiner       | cause. Enter Underlying Cause (Disease or injury RESPIRATORY FAILURE   |  |
| ficate be executed a physician and strensit   | fedical Exa    | resulting in death) Last  Due to (or as a consequence of):  PNEUMONIA  |  |
| The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  | 23d. Date of delivery<br>Month Day Year  |
| requires that<br>een signed by  | by             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CARDIOMYOPATHY   | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown                  |
| The law requir<br>cate has been s<br>page 2 should  | Completed      | RENAL INSUFFICIENCY  | 24a. Was an autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No                              |
| hysician: Th  | Be             | Hospital: 1  | ath (Check only one)   |
| aling Phy  After this funeral d   | on: To         | 1  Yes 2 No  | Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred                                      |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica  | Certification: | 2 Accident investigation 3 ☐ Suicide 4 ☐ Homicide investigation  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                                |
| To the Hospita within 24 hours To the Funeral completely filled   | edical C       | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.                         | pe, and due to the cause(s) and manner as stated.  curred at the time, date and place, and due to the cause(s) |
| To th<br>within<br>To th<br>compl   | Me             | 29b. Signature and title of certifier  No. 29c. License number  D31826   | 29d. Date signed (Month, Day, Year)  4 - U - O 8   |
| 6   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RICHARD L. LINTHICUM, M.D. 76Ø1 OSLER DRIVE  | TOWSON, MARYLAND 21204   |
| St  | ate            | 31. Date filed (Month, Day, Year)  APR 1 4 2008  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** gnes 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Street ombard Year If Under 24 Hrs. Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) ce (State or Foreign Funeral 1 □ M 2 💢 F 130-09-5525 Director 110 Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No **Funeral Director** MD Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ?7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be re USA Pages 1 and 2 should be filed within 72 hours after death vern of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Completed by 3 Widowed 4 Divorced WhiTe 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medica 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental 95 19a. Informant's Name/Relationship (Type. Print) for some land 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD Department of Health a Important: If item 27 is any injury or other tra once. ree 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Mount Crenatory 4/10/08 4 Donation 5 Dother (Specify) reen 21. Signature of Funeral Service Licenses 22. Name and Address of recility Juseph or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myoca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Unterposted Light 82 Alowscur Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed HYTER CHUS RENOW has been signed by the attending physician and je 2 should be detached for use as the bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□No 1□ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 519 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and lin Cropper W. A Bus

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

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2008

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major usamore

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Manth 2008 TO **Physician** 4:00p.M Belon Nathan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dundalk Baltimore 730 Peach Orchard Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑**M 2□ F Months 80 SC 220-22-4971 Director 12 1927 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28e-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2K No Dundalk Baltimore Director MD 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ö USA 21222 730 Peach Orchard Lane or Items 23e death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 2 should be filed within 72 hours atter of and Mental Hygiene. Is marked other then "neturel", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Specify: Black Š Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AT&T 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Moody Dicey Joseph Belon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n eny injury or other traun once. 97 3424 Elmora Avenue Baltimore, MD 21213 Florence Scott-niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills Garrison Forest VA 4/21/08 ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee 1101 E. North Avenue Baltimore, MD 21202 Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on \_ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a con- uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner use as the burial-transit law requires that the death certificate be executed the attending physician and Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Vesidence 6 Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Mann of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Attert the Hospitel or Attending 1 atural 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the 29d. Date; signed (Month, Day, Year) 29b. Signature and title of certifier, 29c. License number ٥ 2008 AYI e of death (Item 23a) (Type, Print) wite 31. Date filed (Month, Day, Year) M. Registrar's Signature State 1 4 2008 Registrar

State Registrar ci 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7.54 AM Button April 10 2008 Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belair Upper Chesapenke Medical Center Has force 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Maryland Maryland Days 1 M 2 □ F 220-04-2381 Director 27,1983 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No itarford Director Jarrettsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 Sharon USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Q No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie
Important: If item 27 is marked other tt
any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shoron Robert Button 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Anatomy Gifts Reas try April 14, cove |
22. Name and Address of Facility Anatomy Eiths Registry 1076 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 24 hours NEUMONIA /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MUSCLE 1 ☐ Yes 2 ☐ ¥60 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 2 1 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attent within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 00056296 4-10-2008 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) M.D. 500 Upper Chesaparko Dr. Bel Air, MD 21014 lason Birnbaum M.D.

Registrar

State

31. Date filed (Month, Day, Year)

APR 1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2008<sup>Year</sup> 12<sup>Day</sup> Physician Bernier 5:12 a M Ann С. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | FeD 27, Year) 931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**X** F ∀ĭrginia 77 227-36-0537 Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating the notified at Director Baltimore 1 ☐ Yes 2√2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Edgewood Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 TNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify If Yes, Give Year or Dates: \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnet Pipes. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caravati Louis J. Johanna ၉ Lyons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Bernier, Jr./ Husband 1800 Edgewood Road Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4-17-08 4 ☐ Donation 5 ☐ Other (Specify) Richmond, Va. 21. Signature of Funeral Service Licensee Towson, Home, York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTA TEARL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Hospital or Attending Physiclan; The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pont 1 Yes 2 No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Day 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate I perform 1 ☐ Yes 1 ☐ Yes 2 □No director, 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Dother (Specify) WOSP W this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 □Yes 2 □No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 12-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature a 29c. License number ad title of certifier

State Registrar Date filed (Month, Day, Year)

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2008

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banks ST TOWSON MD 21204

ame and address of person who completed cause of death (Item 23a) (Type, Print)

M GDI 32. Registrar's Signature

|  |                     | For State   | State of Ma  | ryland / Dep                       | artment of F<br><i>rtificate of</i>                        |   | , ,                                       | 0.00                                      | 0 11070   |
|--|---------------------|---|--|------------------------------------|--|---|---|---|---|
|  |                     | Registrar  1. Decedent's Name (First, Middle, Las   | t)   |                                    | Timeate of   | Death   | 2. Date of Dea                            | leg. No.                                  | 3. Time of Death  |
| Physicia<br>/Medic   | _                   | Surelle L.  | Van Besi   | en                                 |  |   | Month<br>AFRIL                            | Day Ye                                    | 108 04:54FM   |
| Examin   | -                   | 4a. Facility Name (If not institution, give Saint Joseph  |  | Center                             | 4b. City, Town, o  | r Location of Death<br>TOWS                             | on  | 4c. County of E                           | Death<br>altimore   |
| Funeral<br>Director  |                     | 5. Social Security Number 6. S  | ex 7. Age  | (In yrs. last birthday,<br>Yrs.    | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth<br>(Month, Day<br>Dec. 1 | 2, 1930 <sup>9.</sup>                     | Birthplace (State or Foreign Country) New York            |
| w .  |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or Le              | ocation  |   |   |   | 10d. Inside City Limits                                   |
| Maryl:<br>f sho  | ļo                  | MD Baltimo  | 1  | Towson                             |  |   |   |   | 1 ☐ Yes 2 🛣 No  |
| r 28a  | irec                | 10e. Street and Number  |  |                                    | 10f. Zip Code  |   | 1   | 10g. Citizen of Wha                       | t Country?  |
| th witl<br>23a o<br>1st be   | al D                | 43 Judges Lane  |  |                                    | 21 20  | 4   |   | USA                                       |   |
| aryland 21215-0036 should be filed within 72 hours after death with the Maryland not Mental Hyglene. in marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent E-<br>Armed Forces?<br>1 ☐ Yes ② No<br>If Yes, Give<br>Year or Dates: |                                    | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☑ No | tispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)          | Black, V                                  | American Indian,<br>Vhite, etc.<br><b>White</b>           |
| 72 h<br>72 h<br>"natu  | etec                | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. Dece                          | dent's Usual Occup   | oation<br>during most of work<br>d)                     | ing                                       | 16b. Kind of Busine                       | ess/Industry  |
| within ene.  | Be Completed by     | Elementary/Secondary (0-12)   | College (1-4or 5+  | )                                  | <i>boworuserenne</i><br>nemaker                            | u)  |   | Own                                       | Home  |
| Hiled<br>Hygi<br>other<br>ent, t   | ပို                 | 17. Father's Name (First, Middle, Last)   | ·  |                                    |  | 18. Mother's Name                                       | e (First, Middle,                         | Maiden Surname)                           |   |
| Iryland 2<br>should be filed<br>ad Mental Hygi<br>marked other<br>matic event, t   | 10 B                | Isadore Bernste   | in   |                                    |  | Fannie  | Wolfe                                     |   |   |
| y, Maryland 21215-0036 and 2 should be filed within 72 hours af eaith and Mental Hyglene. n 27 is marked other than "natural", or her traumatic event, the Medical Exam  |                     | 19a. Informant's Name/Relationship (7 Maurice Van Besie   |  | use) 43 3                          | Judges La  | and Number or Run<br>ne , Tows                          |   | yland 21                                  | 204   |
| Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev   |                     | 20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify   | "  | Dulaney                            | watory or other place<br>Valley Me                         | m. Grdn.  | P4*/2008                                  |   | n, Maryland   |
| Ball<br>permit<br>Depart<br>Import<br>any in   |                     | 21. Signature of Furieral Service Licen   | \$46   | 7                                  | 2. Name and Addre<br>1Π5Π York                             | ess of Facility Ru<br>Road, To                          |   |   | 1 Home, Inc.<br>21204                                     |
|  |                     | 23a. Part1. Ent in the disease, or compshock, or heart failure. List only   | olications that caused to<br>one cause on each line                                    | he death. Do not en                |  | A. 600  |   |   | Approximate<br>Interval Between<br>Onset and Death        |
| Physician<br>/ /Medical  |                     | Immediate Cause (Final disease or condition resulting in death)   | и  | RESFIRAT consequence of):          | ORY FAI  | LURE  |   |   | DAYS  |
| Examiner   | _                   | Sequentially list conditions,   | b. PNEUMO  |                                    |  | _   |   |   | DAYS  |
| red red  | nine                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (or as a  | consequence of):                   |  |   |   |   |   |
| execu  | Examiner            | that initiated events<br>resulting in death) Last   | cDue to (or as a   | consequence of):                   |  |   |   |   |   |
| cate be executed physician and the burial-transit  | dical               | •   | d  |                                    |  |   |   |   |   |
|  |                     | IF FEMALE:  | One If were outcome in   | f programmer.                      |  |   |   |   |   |
| the death certifity the death certifity by the attending lached for use as   | Physician/Me        | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☒ No<br>9 ☐ Unknown   | 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown                  | Fetal death 3                      | □Ectopic pregnanc<br>□ Other (specify) _                   | у   |   | 23d. Date of<br>Month                     | delivery<br>Day Year                                      |
| be d   | þ                   | Part II. Other significant conditions o   | ontributing to death but   | not resulting in the u             | Inderlying cause giv                                       | ven in Part I.  | 23e. Did to                               |   | te to the cause of death?  Probably 4 Unknown             |
| dr a a a   | Completed           |   |  |                                    |  |   | 24a. Was a                                | an 24b. Wer                               | e autopsy findings available<br>to completion of cause of |
| The ate h  | Com                 |   |  |                                    |  |   | autop:<br>perfor<br>1∐ Yes                | med?   deat                               | h?<br>Yes 2 No  |
| Or VITal Physician: T r this certificat ral director, ps   | Be (                | 25. Was case referred to medical examiner?  | Lib-t  |                                    | T  | 26. Place of Deat                                       | h (Check only or                          | ne)                                       |   |
| ا الله الله الله الله الله الله الله ال  | ဥ                   | 1 ☐ Yes 2 No  27. Manner of Death   | Hospital: 1 1 Inpatien  28a. Date of Injury  |                                    |  | 4 LI Nursing Ho   |   | ence 6 Other (                            | Specify)  |
| ath.   | ation:              | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day  |                                    | Wor  | ryat<br>rk?<br> Yes 2 □ No                              | 28d. Describe h                           | ow injury occurred                        |   |
| DIVISION al or Attending s after death. I Director: After d in by the fune   | Certification:      | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of injur<br>building, etc.  | y - At home, farm, st<br>(Specify) | reet, factory, office                                      |   | 28f. Location (S<br>City or Tow           | treet and Number o<br>n, State)           | r Rural Route Number,                                     |
|  | Medical (           | 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example 1 Medical Example | ysician: To the best of<br>niner: On the basis of<br>and manner stat                   | examination and/or in              | th occurred at the tinvestigation, in my                   | me, date and place,<br>opinion, death occur             | and due to the cred at the time, o        | cause(s) and manne<br>date and place, and | er as stated,<br>due to the cause(s)                      |
| Withii To th   | Š                   | 29b. Signature and title of certifier   |  |                                    | 29c. Licens  |   | 2   | 29d. Date signed (N                       | _   |
|  |                     | (Gribble  |  |                                    | D63  | 974   |   | 4/10/01                                   | <i>y</i>  |
| 0  |                     | 30. Name and address of person who  |  |                                    |  | 7771.167654   | MATNA                                     | Thur of or                                | 1/1   |
| Sta  | te                  | IRMAN SIDDIGI. 31. Date filed (Month Day, Year) APR 1 4 20  | M D 76   | 's Signature                       | C DICIVE   | TOWSON.   | PIPER Y L                                 | WILE CIVIL                                | t mg  |
| Registr  | ar                  | APR 14 20   | 18   | No stage                           | in the state of  |   |   |   |   |
| DHMH 17 Rev 1/20   | 01                  |   |  |                                    |  |   |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Riva Belkowitz Baltimore, Maryland 21215-0036 Pahent Known as

Fur Dire

Physic /Med Exam

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

|   |                     | 1 - For<br>State<br>Registrar  | State of Ma   | aryland /                             | •  | of Health and of Of Death  | Mental H                                       | ygiene<br>Reg. No.                  | 008                          | 11980   |
|---|---------------------|--|---|---------------------------------------|--|--|--|-------------------------------------|------------------------------|---|
| ysici<br>Medic  |                     | Decedent's Name (First, Middle, Last, RIVA   |   | BE                                    | ELKOWITZ   |  | 2. Date of D<br>Month                          | Day                                 | Year<br>2009                 | 3. Time of Death                              |
| amir<br>eral  |                     | 4a. Facility Name (If not institution, give Since 150) and 150 | Ballimon  | e (In yrs. last b                     | Balt   | own, or Location of Deal<br>More City<br>1 Year   If Under 24 Hrs<br>Days   Hours   Min. | 8. Date of B                                   | irth                                | nty of Death                 | place (State or Foreign                       |
| 7   | or                  | Usual Residence of Decedent  10a. State  10b. County  MD  N/A  |   | 1                                     | vn or Location   |  |  |                                     |                              | 0d. Inside City Limits 1 ☑ Yes 2 ☑ No         |
| any injury or other traumatic event, the Medical Examinar must be notified at once. | eral Director       | 10e. Street and Number 7219 PARK HEIGHT  |   | 403                                   | 10f. Zip   | 21208  |  | 10g. Citizen o                      | SA                           | ntry?   |
| Examination   | d by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 X N<br>If Yes, Give<br>Year or Dates:      | 10                                    | 1 □Yes 2   |  | Specify Yes or N<br>to Rican, etc.)            | Spec                                |                              | etc.<br>ITE                                   |
| the Medica  | Completed           | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>e completed)<br>College (1-4or 5<br>2   |                                       | a. Decedent's Usua<br>(Give kind of worn<br>life. DO NOT us<br>BOOKK | - dama' di inimu un 3 - 6  | orking   | 1                                   | TFILO                        | H CAMPS                                       |
| atic event,   | To Be (             | 17. Father's Name (First, Middle, Last) SAMUEL   | BAR   |                                       |  | 18. Mother's Na  | ₹  | FF                                  | RIEDMA                       |   |
| ther traum  | . 10                | 19a. Informant's Name/Relationship (T); SAMUEL BELKOWITZ   | •   | 5                                     | 120 WALT   | ON AVENUE,   | PHILADEL                                       | PHIA, F                             | PA 19                        | 143   |
| njury or ot   |                     | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)   |   | cemete                                |  | E CORP. 04/1   |  | TOWSON                              | V, MD                        |   |
| any i   |                     | 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or compli   |   | the death. Do                         | 8900   | REISTERSTOW  |  | - PIKES\                            |                              |   |
| ian<br>ical<br>ner  | Examiner            | Shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to or as a  | e. Fu  a consequence B  a consequence | ilure<br>of:<br>llians   | jir/hosis  | o o i respiratory                              | unos,                               |                              | Interval Between<br>Onset and Death<br>DCLLLS |
| se as the burial-transit  | edical              | resulting in death) Last   | Due to (or as a   | a consequence                         | of):   |  |  |                                     | =3                           |   |
| tached for u  | Physician/M         | in the past 12 months? 1  Yes 2 No 9 Unknown   | 1  Live birth 4  Pregnant at 9  Unknown   | 2 Fetal death<br>time of death        | 5 Other (spe   | cify)  |  |                                     | Date of delive<br>Month      | ery<br>Day Year                               |
| should be de  | þ                   | Part II. Other significant conditions con  |   |                                       |  |  | 1 🗆  | Yes 2 No                            | 3 ☐ Prob                     |   |
| tor, page 2 s   | e Completed         | Mpothyroid iSN  25. Was case referred to medical   | 1   |                                       |  | 26. Place of De  | perl<br>1 ☐ Yes                                | opsy<br>formed?<br>2 L <b>X</b> Vo  | prior to cor<br>death?       | psy findings available mpletion of cause of   |
| completely filled in by the funeral director, page 2 should be detached for use as  | Certification: To B | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined   | ospital: 1 Inpatie  28a. Date of Injur<br>(Month, Day  28e. Place of Injur<br>building, etc | y (28b. / Year) 28b.                  | utpatient 3 DO. Time of Injury M  arm, street, factory,              | Other: 4 \sum Nursing F<br>c. Injury at<br>Work?<br>1 \supersymbol Yes 2 \supersymbol No | Home 5 ☐ Res<br>28d. Describe<br>28f. Location | sidence 6 C                         | urred                        | y)<br>Il Route Number,                        |
| pletely tille   | Medical C           | 29a. Certifier (Check only one)  12 Certifying Phys 2 Medical Examination  | sician: To the best of<br>ner: On the basis of<br>and manner sta                            | examination a                         | e, death occurred and/or investigation,                              | t the time, date and plac<br>in my opinion, death occ                                    | e, and due to thurred at the time              | e cause(s) and<br>e, date and place | manner as s<br>e, and due to | stated.<br>the cause(s)                       |
| Com   |                     |  | MD  | anh (learn on                         |  | License number<br>RES-000<br>Balbimor  |  | 29d. Date sign                      | 9, ZC                        | Day, Year)<br>DD $eta$                        |
| Sta   |                     | 30. Name and address of person who co  | mpleted cause of de<br>Se, MD<br>32. Registra   | Sinailt                               | USPITA OF  | Ballimon   | ٤  |                                     |                              |   |
| gistr   | ar                  | Hrn 1 4 Weg  | A Plan Des  | with the                              | DOME   |  |  |                                     |                              |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2008 **Physician** oril 10.300M /Medical 4c. County of Death 4b. City, Town, or ocation of Death 4a. Facility Name (If not institution, give street and number) Examiner Richey Hospice Bultimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month Day, For 1) 3. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🐼 Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Des 2 No Director 10g. Citizen of What Countr by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ HO Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Maryland Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rugal Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed Approximate Interval Betw Onset and D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** months Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse wence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 □Unknown 2 □ No 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Director; After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice 50 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 21:06 PM KATHRYN CANBY MARLY APRIL 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD HOWARD COUNTY GENERAL MOSPITAL COLUMBIA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1□M 2XF Hours December29, 1947 Maryland 213-48-1225 Director 60 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes X No Maryland Carroll Eldersburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 U.S.A. 2032 Sherryl Avenue by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 【☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Collision Repair Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Watson Jean Convery ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2032Sherryl Avenue, Eldersburg, Maryland 21784 <u>Joseph L. Canby/Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-12-08 Baltimore Maryland Bayview Crematory 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael F. Mer 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HUTE RESPIRATIONY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** RATTERIAL PNEUMWIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown RHEUMATOND ALTIMUTIS 24b. Were autopsy findings available prior to completion of cause of death? SYSTEMIC LUPUS ERYTIEUMAMPSSIS 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ ₩o 2 No Within 24 hours area.

To the Funeral Director. After this ver... 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APPIL 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE MANXONT PARKWAY COLUMNS A MO 21044 DAVID 0- PYMIM

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 14 2008

**ORIGINAL** 

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 4a. Facility Name (If not institution, give street and num Claridge 10 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Bult: More Johns Hopkins Buyview Medical HImore Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 F Months Hours Director 216-18-9936 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 48th Street 21224 628 S. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In own home Home maker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pasquale Tosches Caroline Tosches ပ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell J. Claridge 48th St. Baltimore Maryland 21224

Vame of Date 20c. Location - City or Town, State 628 S. 48th

20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Jesus 4/14/2008 Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. re of Funeral Service Licensee 21. Signat FH 263 Conkling St. Baltimore, MD 21224 S. Part \ Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Days Physician 104515 /Medical Due to (or as a consequence of) **Examiner** week neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the attending ph I for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has director, page 2: performe death? 2□ No certificate 1☐ Yes 2 No **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) Injury Hospital or Attending 1 Natural 5 Pending investigation within 24 hours are to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) emen 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Q Avenue Billimore, MD 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 11:30 PM Stuart R. Drenning APRIL 8 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SINAL HOSPITAL OF BALTIMORE CITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Abouthe Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X**□M 2□F 221-26-2508 89 Jan. 30, 1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 👿 No Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6336 Cedar Lane, Apt. 266 21044 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1√Yes 2 No If Yes, Give 38-68 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Marine Corps 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stuart Ruby Drenning Emma Rose Pressler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Pitts- daughter 9104 Jefferson St., Box 257, Savage, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cemetery April 16,2008 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, INC. Mych 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) VENTRICULAR TACHYARR HYTH MIA Due to (or as a consequence of): ISCHEMIC 6 months CARDIOMYDPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No

Physician /Medical Examiner

Important: If it any injury or o Department of

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f sh notified

a or

or items

"natural", or item: ledical Examiner

7 is marked other than "natu traumatic event, the Medical

filed within 72 hours after Hygiene.

Pages 1 and 2 should be 1 nent of Health and Mental

Baltimore, Maryland 2121

Director

Funeral

Completed by

Be

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attending physician and for use as the burial-tran signed by the a d be detached f

Division or Vital Records, P.O. Box 68760,

Attending Physician:

To the Hospital or

Examine Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

| 9 ☐ Unknown  | 9∐Unknown  |  |
|--|--|--|
| Part II. Other significant conditions of CONGESTIVE HEA                | ontributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2☐ No 3 ☐ Probably 4 ☐ Unknown |
| CHRONIC KIDNE  | Y DISEASE  | 24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 2 No 1 Yes 2 No                          |
| 25. Was case referred to medical                                       |  | h (Check only one)   |
| examiner?<br>1 ☐ Yes 2 ☐ <b>N</b>                                      | Hospital: 112 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho  | me 5 ☐ Residence 6 ☐ Other (Specify)   |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) Injury Work?  I  | 28d. Describe how injury occurred  |
| 3 Suicide 6 Could not be<br>4 Homicide determined                      | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                |
|  | ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. |  |

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

APRIL 8, 2008

0

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CIM

DEEPA RAGHAVAN, MD SINAL HOSPITAL OF BAUTIMORE

31. Date filed (Month, Day, Year) APR 1 4 2008

29b. Signature and title of certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|             |   |                     | For<br>State<br>Registrar  | State of   | Marylan  | -                               | artmen<br>rtificat                              |                           |                                       | and Me                      |  | giene<br>Reg. No. | 008                                  | 9                                   | 35            |
|-------------|---|---------------------|--|--|--|---------------------------------|---|---------------------------|---------------------------------------|-----------------------------|--|-------------------|--------------------------------------|-------------------------------------|---------------|
|             | Physici   | an                  | 1. Decedent's Name (First, Middle, Virginia  | G. Decke   | r  |                                 |   |                           |                                       |                             | Date of Dea                            |                   | 2008 <sup>ar</sup>                   | 3. Time of 5:25                     |               |
|             | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, Glen Meado  | give street and numb                                     |  |                                 |   | Town, or<br>len           | Location o                            |                             |  | 4c. C             | ounty of Dea<br>Baltin               |                                     |               |
|             | Funeral<br>Director   |                     | 5. Social Security Number 212-10-9502  Usual Residence of Decedent   | 5. Sex<br>1 □ M <b>2/</b> □ F                            | Age (In yrs. 91  | last birthday)<br>Yrs.          | If Under<br>Months                              | 1 Year<br>Days            | If Under 2<br>Hours                   | Min. N                      | Date of Birtl<br>(Month, Pay<br>OV • 4 | 1916              | 9. Bir<br>M                          | thplace (State of<br>aryland        | r Foreign     |
|             | a-f show  | ctor                | 10a. State 10b. County Md. Balti   | more   |  | y, Town or Lo                   | cation  |                           |                                       |                             |  |                   |                                      | 10d. Inside Cil<br>1 ☐ Yes          |               |
|             | with the  | I Dire              | 10e. Street and Number<br>2 Southerly Co   | urt #602   |  |                                 | 10f. Zip  | 212                       | 86                                    |                             |  | 10g. Citize       | n of What C                          | ountry?<br>SA                       |               |
| 920         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Extentinational be notified at 80cs. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced  | 12. Was Deced  | es?<br>ſ <b>X</b> No   | - 1                             | Was Deced<br>If Yes, spec                       |                           | spanic Orig<br>n, Mexican<br>Specify: | gin? (Speci<br>i, Puerto Ri | fy Yes or No-<br>can, etc.)            | ,                 | Race - Am<br>Black, Whi<br>pecifyWhi |                                     |               |
| 21215-0036  | Jwithin 72 ho<br>piene.<br>r than "natur<br>the Medical.  | Completed           | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)   | Education<br>grade completed)<br>College (1-4            | or 5+)   |                                 | dent's Usua<br>kind of wo<br>DO NOT us<br>emake | rk done d<br>se retired   | ation<br>during most<br>)             | t of working                | ,                                      |                   | of Business                          |                                     |               |
| Maryland 2  | should be filed<br>nd Mental Hygi<br>r marked other<br>umatic event, I  | To Be C             | 17. Father's Name (First, Middle, L<br>Edward P. Ge  | nt   |  |                                 |   |                           | Ada                                   | Mars                        |  |                   |                                      |                                     |               |
|             | nd 2 shall all and 27 is m  |                     | 19a. Informant's Name/Relationshi<br>Mr. Lowell Bowen  |  | /  | 19b. Mailir                     | W. Pe   | nnsy                      | lvani                                 | a Ave                       | Ro <i>ute Numbe</i><br>. Suit          | e 900             | Town, State,                         | on, Md.                             | 21204         |
| Baltimore,  | Pages 1 a<br>nent of Hes<br>ant: If item<br>ury or othe   |                     | 20a. Method of Disposition 1 ☐ Burial 2 (X) Cremation 4 ☐ Donation 5 ☐ Other (Sp.  |  | ate  | Place of Dispo<br>emetery, crei | <sub>natory`or o</sub><br>Servi                 | ce C                      | 0.                                    | Dat<br>4-14-                | 08                                     | Tov               | ution - City or                      | Town, State                         |               |
| Balt        | permit. Departr Imports any inji  |                     | 21. Signature of Fuperal Service L.  23a. Part1. Enter the disease, or of  | 40   |  |                                 |   |                           |                                       |                             | 1 Home<br>on, Mc                       |                   | 204                                  | Approximate                         |               |
| 68760, %    | cate be executed /Medical Examine bhysician and burial-transit sthe burial-transit  | ical Examiner       | shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | a. ue y (or  | ch line.  Card  ras a conseq  state a conseq  ras a conseq  ras a conseq | uence of): uence of):           | Inja  | rcho                      | ~<br>outo                             | √ el                        | NI CENT                                | 2                 |                                      | interval Beh<br>Onset and I<br>Dudd | ween<br>Death |
| P.O. Box 68 | ath certifi<br>ttending<br>or use as  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown   |  | h 2 ∏ Feta<br>ntattime of d  | Ideath 3                        | □Ectopic pr<br>□ Other (sp                      |                           |                                       |                             |  | 23                | d. Date of de<br>Month               |                                     | /ear          |
|             | uires that the de<br>signed by the a<br>Id be detached f  | by                  | Part II. Other significant condition   | s contributing to dea                                    | th but not res   | ulting in the u                 | nderlying o                                     | ause give                 | en in Part I.                         |                             | 23e. Did to                            | 1                 |                                      | o the cause of d                    |               |
| I Records,  | The law requir<br>ate has been si<br>page 2 should I  | Completed           | Hyps Myrord  | om   |  |                                 |   |                           |                                       |                             | 24a. Was                               | an                | 24b. Were a prior to death?          | utopsy findings<br>completion of c  | available     |
| of Vital    | sician:<br>s certific<br>lirector,  | To Be               | 25. Was case referred to medical examiner?   | Hospital:  | nationt 2  | EP/Outpatier                    | nt 3 🗆 DC                                       | Oth                       | -                                     |                             | Check only o                           |                   | Other (Sp                            | ecify)                              |               |
| Division of | To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.   | Certification; T    | 27. Man of Death  1 Platural 5 Pending 2 Accident investigs 3 Suicide 6 Could no   | 28a. Date of (Month,                                     | Injury<br>Day Year)  | 28b. Time o<br>Injury           | f M   | 28c. Injun<br>Work<br>1 🗀 |                                       | 28<br>No                    | d. Describe h                          | now injury        | occurred                             | iural Route Num                     | her           |
| DIV         | tal or A  | Certif              | 4 Homicide determin  | building   | , etc. (Specil   | y)                              | eet, factory                                    | y, Onice                  |                                       |                             | City or Tov                            | vn, State)        |                                      |                                     |               |
|             | To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I   | Medical             | (Check only 2 Medical E  | Physician: To the be<br>xeminer: On the bas<br>and manne | is of examina<br>r stated.   | wledge, deat<br>ition and/or in | vestigation                                     | , in my o                 | pinion, dea                           | d place, an<br>th occurred  | at the time,                           | date and p        | lace, and du                         | e to the cause(s                    | )             |
|             | To To corr  | 2                   | 29b. Signature and title of certifier  | My   | ) III  | 20.1                            | 290   | 030                       | o number<br>9435                      |                             | , ma                                   | April Date        | signed (Mon                          | lth, Day, Year)                     |               |
| _           | 19  |                     | 30. Name and address of person w   | m ( 6 1)   | of death (Item   | 1 23a) (Type,                   | o A   | T                         | my                                    | more                        | · Ma                                   | 212               | 104                                  |                                     |               |
|             | Sta<br>Registi  |                     | 31. Date filed (Month, Day, Year)  APR 1 4   | 2008 32 Re   | gistrar's Signa  | ature                           |   |                           |                                       |                             |  |                   |                                      |                                     |               |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 2008 **Physician** John Frank Derrickson 12 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X**M 2□F 213-03-5288 90 November 22,1917 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Baltimore Timonium Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 2117 Starmount Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sales security sales engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Metcalf Derrickson Loretta Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ann Yingling/daughter 138 Hahn Rd. Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem Gard'Apr. 14,2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John (). Mitchell IV, Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPMS Due\_to (or as a consequence of): TWONT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) þ Be Completed

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Funeral

Director

notified

28a-f

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

the burial-tra attending pl Certification: To after death within 24 hours after To the Funeral Di completely filled ir

Division or Vital Records, P.O. Box 68760,

| 1 □ Yes 2 □ No<br>9 □ Unknown  | 9□Unknown                                |                             |                                     |  |
|--|--|-----------------------------|-------------------------------------|--|
| Part II. Other significant conditions                                | -  | ulting in the underlying    | g cause given in Part I.            | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2  90 3  Probably 4 Unknown                     |
|  |  |                             |                                     | 24a. Was an autopsy performed?  1  |
| 25. Was case referred to medical                                     |  |                             | 26. Place of Dea                    | ath (Check only one)   |
| examiner?<br>1 ☐ Yes 2 ☑ No  | Hospital: 1 ☐ Inpatient 2 ☐              | ER/Outpatient 3             | DOA Other: 4 Nursing H              | lome 5 Residence 6 Sother (Specify) DOVE HOV   |
| 7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio | 28a. Date of Injury<br>(Month, Day Year) | 28b. Time of<br>Injury<br>M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred  |
| 3 ☐ Suicide 6 ☐ Could not be determined                              |  | ome, farm, street, fact     | ory, office                         | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                                |
|  |  |                             |                                     | e, and due to the cause(s) and manner as stated.<br>urred at the time, date and place, and due to the cause(s) |

29c. License number

30

30. Name

29d. Date signed (Month, Day, Year) 04-13-00

nd address of person who completed cause of death (Item 23a) (Type, Print)
Flavio W Kruter MD 555 South Center Street Westminster Maryland 21157

State Registrar

Medical

29b. Signat

re and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** ELDRINGE PHYLLIS B. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner But more
If Under 1 Year | If Under 24 Hrs. univerity of mary and medical Center Date of Birth (Month, Day, Year) 10-2-1956 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 💢 F 51 MD Director 213-72-7531 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adloal Examiner must be notified at Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 537 N. Pulaski Street 21223 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Food Service Hygiene. N/A Disabled 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Leon Johnson Lorraine Smackem ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21217 Tiffany Eldridge-Daughter 2107 Westwood Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 □Cremation 3 □Removal from State 4-16-2008 Balto, MD Carmel Cem 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licenses lady 1101 E. North Avenue Balto, MD 21202 Wans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stone 2 4 cms disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseque Examiner law requires that the death certificate be executed a la Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: Jse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, 2 No 3 Probably 4 Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? Yes 2 No certificate has page 2 1∐ Yes Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Denpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending Injury 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . South Greene Street, Room N3ED9 Bultimore, Maryland

State Registrar

31. Date filed (Month, Day, Year)

22

4

2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #3 Per PHY G879 5/28/08 THI Cate of Death

Red, No. 7:10 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 10, Day 2008 Year **Physician** Martin Feldman /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Westmin's ter Carroll Home Care and Hospice Carrol1 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/30/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days 82 M 2 ☐ F 128-16-2005 NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or Items 23a or 28a-f show dical Examiner must be notified at Baltimore Catonsville MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 21228-3606 10g. Citizen of What Country? USA 6 Carroll Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? NEWes 2 □ No NEVY If Yes, Give 1942–1945 Year or Dates. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ★ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: à 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natur
any Injury or other traumatic event, the Medical I
onee. 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textiles Manager 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadve Freidberg Samue1 Fe1dman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll Road, Catonsville, MD 21228-3606 Colleen M. Feldman / Wife

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Moses Cemetery

Date

22. Name and Address of Facility Charles L. Stevens Funeral Home Inc.

04/14/2008

1501 East Fort Avenue, Baltimore, MD 21230

20c. Location - City or Town, State

Pinelawn, NY

**Physician** /Medical Examiner

20a, Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

APR 1 4 2008

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

within 24 hours after deatl To the Funeral Director:

|   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of   | lications that caused the death. Do none cause on each line.  | ot enter the mode of dying,                                   | such as cardiac or re                         | espiratory arrest,                                 |   | Approxim<br>Interval E   | Between                 |
|---|---|---|---|---|--|---|--------------------------|-------------------------|
|   | Immediate Cause (Final disease or condition   | a Carme   | Cloute les  | ins. I  | allin  |   | Onset an                 | d Death                 |
| al Examiner                             | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of Due to (or as a consequence | or):  | 8 1   |  |   | 11510                    | \$ 4/2010               |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | d   | 3 □Ectopic pregnancy<br>5 □ Other (specify)                   |   |  | 23d. Date of del<br>Month                     | ivery<br>Day             | Year                    |
| ed by Pł                                | Part II. Other significant conditions of  | ontributing to death but not resulting in   | the underlying cause given                                    | in Part i.                                    | 23e. Did tobacco u<br>1 ☐ Yes 2 [                  | ise contribute to                             |                          |                         |
| Complet                                 |   |   |   |   | 24a. Was an<br>autopsy<br>performed?<br>1 Yes 2 No | 24b. Were au<br>prior to<br>death?<br>1 □ Yes |                          | s available<br>cause of |
| Be (                                    | 25. Was case referred to medical examiner?  |   |   | 6. Place of Death (C                          | heck only one)                                     | <u> </u>                                      |                          |                         |
| To E                                    | 1 ☐ Yes 2 MNo   | Hospital:<br>1 ☐ Inpatient 2 ☐ ER/Ou  | tpatient 3 DOA Other  | 4 Nursing Home                                | 5 ☐ Residence                                      | 6 □Other (Spe                                 | cify)                    |                         |
| ation:                                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  |   | Time of njury 28c. Injury 28c. Work?  M 1 □ Ye                | at 28d  | . Describe how injur                               | y occurred                                    |                          |                         |
| Sertific                                | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of injury - At home, far building, etc. (Specify)  | rm, street, factory, office                                   | 28f.  | Location (Street and<br>City or Town, State        | d Number or Ri                                | ural Route N             | umber,                  |
| Medical Certification:                  | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam  | vslcian: To the best of my knowledge iner: On the basis of examination an and manner stated.  | , death occurred at the time<br>d/or investigation, in my opi | , date and place, and<br>nion, death occurred | I due to the cause(s)<br>at the time, date and     | and manner as<br>I place, and due             | s stated.<br>to the caus | e(s)                    |
| M                                       | 29b. Signature and title of certifier   | lest the me   | 29c. License  | umber<br>459                                  | 29d. Dat   | te signed (Mont                               | h, Day, Year             | )                       |
|   | 80. Name and address of person who c  | ompleted cause of death (Item 23a) (  | Type, Print)  | Street L                                      | CESTHINE   | en, Hi  | ) 2115                   | フ                       |

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

1

State

Medi

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SKIRATNA KONERU

DHMH 17 Rev 1/2001

29c. License number

RES - 000

SIMAL HOSPITAL OF BALTIMORE

29d. Date signed (Month, Day, Year)

APRIL, 03, 2008

and manner stated.

MBBS

32. Registrar's Signature

Inn MBBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [1] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:00P M GATES APRIL 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMONO SAMARITAN 405117AZ 6000 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yell 11–22–31 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 256-46-9001 GA 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County MD BALTIMORE 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be r 1701 EUTAW PLACE 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DELIVERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be GATES MAGGIE GADSON ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other tratonce. 1701 EUTAW PLACE APT 410, BALTO., MD 21217 NELL GATES/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METRO CREMATORY 4/11/08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signeture of Funeral Service Licenses 1701 LAUREENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PNEUMON IF Sequentially list conditions, if any, leading to immediate cause. El ter or deliving Cause (Disease or injury Examiner certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical the as attending properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the detached o 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ò DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 ☐Inpatient Certification: To 28b. Time of 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide fo the within 24 hour.
the Funeral D 1 ritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registra

31. Date filed (Month, Day, Year) APR 1 4 2008

GOOD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A77843129

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APRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death Day **Physician** 7:20 PM 2008 PMI ricia /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silvers Pring

If Under 1 Year | If Under 24 Hrs. | 6 Date of Birth (Month, Day, Year)

Adouths | Days | Hours | Min. | (Month, Day, Year) MO HOSpita 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 22450072 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code lehawken 20816 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 1 Yes 2 WNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker touse wife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elleen Smothers Maddock oha Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5421 Mohican Rd. Bethesda, MO 20816 Patrick Gates 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/11,2008 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Riverdale Crematory Riverdale, MD 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licens 22. Name and Address of Facility State Funeral Service ltu w Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rediate Cause (Final disease or condition resulting in death) Myocardial **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examiner neumonia burial-trar be execu Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> docarditis 2XNo 3 Probably 4 Unknown 1 ☐ Yes Completed Cancer varian 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 
No 24a. Was an has page 2: autops) certificate 1 Yes 2 □ No So the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 npatient 2 ER/Outpatient 3 DOA မှ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

O. Box 68760,

Records,

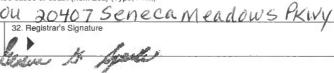
Division or Vital

State Registrar

APR 1 4 2008

31. Date filed (Month, Day, Year)

30. Name and address of vers in who completed cause of death (Item 23a) (Type, Print)



**O**RIGINAL

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, DHMH 17 Rev 1/2001

|   |                   |  | e Type or Pri<br>9bPER FH G8  |                               |                                       |   |  | -                                     | _                                       |  |
|---|-------------------|--|---|-------------------------------|---------------------------------------|---|--|---------------------------------------|---|--|
| Physicia<br>/Medic  |                   | 1. Decedent's Name (First, Middle,   |   |                               | Cei                                   | tillicate of t  | <u> </u>   | 2. Date of Death<br>Month<br>April 1  | Day Year                                | 3. Time of Death 11:30ar                           |
| Examin  |                   | 4a. Facility Name (If not institution, Futurecare Irv:   | give street and number,<br>ington   | )                             |                                       |   | Location of Death                                      | 1                                     | 4c. County of Dea                       |  |
| Funeral<br>Director   |                   | 5. Social Security Number 245–42–2584  | 3. Sex 7. A   | ge <i>(In yrs. la</i><br>78   | as <i>t birthd</i> ay)<br>Yrs.        | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth (Month, Day, 12/20/1 | rear) C                                 | rthplace (State or Foreign ountry)                 |
| Maryland<br>f show<br>ied at  | ō                 | Usual Residence of Decedent  10a. State 10b. County  MD  |   | 10c. City                     | , Town or Lo                          |   | Baltimore  | 2                                     |   | 10d. Inside City Limits 1                          |
| n with the<br>23a or 28a<br>st be notif   | al Director       | 10e. Street and Number 2706 Edmondson  | n Avenue  |                               |                                       | 10f. Zip Code <b>21</b> 2                                       | 223  | 10                                    | g. Citizen of What C                    | ountry?  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   | by Funeral        | 11. Marital Status<br>1 □ Never Married 24☑ Marrie<br>3 □ Widowed 4 □ Divorced   | 12. Was Decedent<br>Armed Forces<br>d 1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: | ?                             |                                       | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2X No      | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specity: | ecify Yes or No-<br>Rican, etc.)      | 14. Race - Am<br>Black, Whi<br>Specify: |  |
| thin 72 no<br>e.<br>an "natur<br>Medical I  | Completed         | 15. Decedent's (Specify only highest Elementary/Secondary (0-12)   |   | 5+)                           | (Give                                 | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | durina most of work                                    | sing                                  | 6b. Kind of Business                    | s/Industry   |
| Hygiene<br>Hygiene<br>ther the  |                   | 3<br>17. Father's Name ( <i>First, Middle, L</i>   |   |                               |                                       | Longshore   |  | e (First, Middle, Mi                  | Dry Doc                                 | k  |
| Mental I<br>Mental I<br>arked of<br>atic eve  | To Be             | Forest Hawkins   |   |                               |                                       |   | Robert   | a Sheari                              | n                                       |  |
| and 2 sho<br>ealth and<br>n 27 Is ma<br>ier trauma  |                   | 19a. Informant's Name/Relationshi  | p (Type. Print)<br>Dway / daugh   | nter                          | 19b. Mailir<br>3676                   | ng Address (Street a  | and Number or Rui                                      | d, Ranok                              | e Rapids,                               | Zip Code)<br>NC 27870                              |
| rages in the period He suit of He suit of the suit of |                   | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp  |   | , ce                          | emetery, crei                         | osition (Name of<br>matory or other place<br>ove Church         | e) ¦   | Date 21<br>/16/2008                   | Oc. Location - City o<br><b>Hali</b>    | r Town, State<br>fax, NC                           |
| Departr<br>Departr<br>Importa<br>any inji   |                   | 21. Signature of Funeral Service L   | S. Marson   | all                           | 22                                    | 2. Name and Addres Charles 1                                    | L. Steven  | s Funera                              | l Home Ind                              | C.   |
| Physician /Medical Examiner pnuisi-transit  | Examiner          | 23a. Part1. Enter the disease, or or control of the | a   | s a consequ                   | ence of):                             | Rema /  | g, such as cardiac                                     | or respiratory arres                  | st,                                     | Approximate<br>Interval Between<br>Onset and Death |
| attending physical for use as the   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | d   | 2 🗆 Fetal                     | death 3                               | ⊒Ectopic pregnancy<br>⊒ Other (specify)                         | ,  |                                       | 23d. Date of de<br>Month                | blivery<br>Day Year                                |
| quires una<br>in signed I<br>uld be det   | by                | Part II. Other significant condition   | Scu (v /  | out not resu                  | -                                     | nderlying cause give  | en in Part I.  | 23e. Did toba                         | 5000                                    | to the cause of death?<br>Probably 4  □Unknown     |
| The form of the form of the formula | e Completed       | Demontia<br>25. Was case referred to medical   | Un  |                               |                                       |   | 26. Place of Deat                                      | 24a. Was an autopsy perform 1  Yes 2  | ed? prior to death? ↓ No 1 □ Ye         |  |
| After this certification  | on: To B          | examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending  | Hospital: 1 Inpati<br>28a. Date of Inj<br>(Month, Da                                | ury                           | ER/Outpatier<br>28b. Time o<br>Injury | Worl  | y at   | ome 5 Resider<br>28d. Describe how    | ce 6 □Other (Sp.<br>v injury occurred   | ecify)   |
| o ine nospital or Attending<br>within 24 hours after death.<br>To the Funeral Director: After<br>completely filled in by the funer  | Certification:    | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not determine   | ot be 28e. Place of in  | jury - At hor<br>tc. (Specify | me, farm, str                         | M 1 □   | Yes 2 □ No   | 28f. Location (Stre<br>City or Town,  | eet and Number or F<br>State)           | Rural Route Number,                                |
| n 24 hours<br>ne Funeral  | edical C          | 29a. Certifier (Check only one)  1 Certifying 2 Medical E  | Physician: To the best<br>xaminer: On the basis<br>and manner s                     | of examinati                  | ion and/or in                         | vestigation in my o   | ninion death occur                                     | red at the time da                    | to and place, and di                    | in to the equipo(e)                                |
| within To #   | Me                | 29b. Signature and title of certifier  | /   |                               | 100                                   | 29c. License  | e number   | 296                                   | d. Date signed (Mor                     | nth, Day, Year)                                    |
| 3   |                   | 30. Name and address of person w   | the completed cause of  | death (Item                   | 23a) (Type,                           | Print)<br>Mt. Ro-   | zal Ave  | Balto                                 | d. Date signed (Mor                     | 21217  |
| Sta<br>Registr  |                   | 31. Date filed (Month, Day, Year) APR 1 4  | 61  | rar's Signat                  | ure                                   | barke   | /  |                                       | ,                                       |  |

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760. been signed by the should be detached s certificate has I lirector, page 2 s or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

**Physician** 

/Medical

**Examiner** 

Funeral Director

þ

Completed

Be 2

**Funeral** 

Director

pemil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, The Modical Exemples must be notified at 900s.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

21. Signatore of Funeral Service Licenses Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. Completed by Be 25. Was case referred to medical examiner? ٢ 27. Manner of Death Certification: 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) ark April 10 2164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walcard Aut

Baltimore

DHMH 17 Rev 1/2001

State Registrar

GOODER.

32. Registrar's Śignature

SAMBANDAM BASKSCAN

31. Date filed (Month, Day, Year)

|                   |  |                | Please   | State of Maniana   |                               |  |  | -   | _                                       |  |
|-------------------|--|----------------|--|--|-------------------------------|--|--|---|---|--|
|                   |  |                | 1 _ For<br>State   | State of Maryland  |                               | artment of F<br>rtificate of                 |  |   | -21HR                                   | 1994   |
|                   | 25   |                | Registrar  1. Decedent's Name (First, Middle, Las  | it)  | Cei                           | uncate or                                    | Dealii                                   | 2. Date of Death                                | . No.                                   | 3. Time of Death                                 |
|                   | Physici  |                |  | NDLER  |                               |  |  | Month   | Day Year 2003                           |  |
| Ale<br>M          | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give  |  |                               | 4b. City, Town, o                            | r Location of Deat                       | APRIL 8   | 4c. County of Dea                       |  |
|                   |  |                | Friends House 1  | Jursina Home   |                               | Sa   | nd. 50                                   | na a  | Montge                                  |  |
|                   | Funeral  |                | 5. Social Security Number 6. Se  | ex 7. Age (In yrs. la  | st birthday)                  | If Under 1 Year<br>Months Days               | If Under 24 Hrs<br>Hours Min.            | 8. Date of Birth<br>(Month, Day,                | (ear) 9. Bi                             | rthplace (State or Foreign ountry)               |
|                   | Director   |                | 00 2-10-0304   | □M 2 <b>½</b> F 94   | Yrs.                          | - Sayo                                       |  | January 20                                      | 1,1914 Con                              | neethout   |
|                   | land   |                | Usual Residence of Decedent  10a. State 10b. County  | - 10c. City  | , Town or Lo                  | cation                                       |  |   |   | 10d. Inside City Limits                          |
|                   | Mary<br>Frsh   | tor            | Maryland Monty   | ompru  | 5.                            | andy Sp                                      | 000                                      |   |   | 1 Maryes 2 No                                    |
|                   | h the  | Director       | 10e. Street and Number   |  |                               | 10f. Zip Code                                |  | 10  | g. Citizen of What C                    | ountry?  |
|                   | 1h wit   |                | 17401 Norwood  | Rd   |                               | 20   | 0860                                     |   | US                                      | A  |
|                   | r dea  | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U.S<br>Armed Forces?  | 3. 13.                        | Was Decedent of F<br>f Yes, specify Cubi     | lispanic Origin? (S<br>an, Mexican, Puer | pecify Yes or No-<br>o Rican, etc.)             | 14. Race - Am<br>Black, Wh              |  |
| 36                | s afte   | by Ft          | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 🚝 No<br>If Yes, Give   | 1                             | I ☐ Yes 2 ♣ No                               | Specify:                                 |   | 0- 1/                                   | Vhite  |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>then "naturei", or items 23e or 28e-f show<br>he Medical Ever in er mast be invitited at  | ed k           | 15. Decedent's Ed  | Year or Dates:   | 16a Decer                     | lent's Usual Occup                           | ation                                    | 14  | Sb. Kind of Business                    |  |
| 215               | n "na  | plet           | (Specify only highest grad   | de completed)  | (Give                         | kind of work done DO NOT use retired         | durina most of wo                        | king  | D. King of Dasilles.                    | omoustry   |
| 212               | d with<br>giene  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                               | House u                                      | sife                                     |   | Own                                     | Home   |
|                   | at Hy<br>at Hy<br>d oth  | Be (           | 17. Father's Name (First, Middle, Last)  |  |                               |  | 18. Mother's Na                          | ne (First, Middle, Ma                           | uiden Sumame)                           |  |
| yla               | 2 should be filed within<br>and Mental Hygiene.<br>is marked other then '  | To             | Richmond   |  |                               |  |  | roline  |   |  |
| Maryland          | 12 sh<br>and<br>rs m<br>rs um  |                | 19a. Informant's Name/Relationship (7  | I ii   |                               |  |  | ral Route Number, (                             |   | ,  |
|                   | s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other then "nature!", or items 23e or 28e-f show ther traumatic event, the Medical Executive from the indiffical executive medical Executive from the property. |                | Guren Handler /<br>20a. Method of Disposition  | Daughter   | 935                           | Sition (Name of                              | Kd. U                                    | Date 20   | oc. Location - City o                   |  |
| 5                 | Pages<br>nent of h<br>ant: if its<br>ary or of   |                | 1 ☐ Burial 2 🛣 Cremation 3 🗌   | Removal from State   | metery, cren                  | natory or other plac                         | · · · · ·                                |   |   |  |
| Baltimore,        | permit. Pages 1 a<br>Department of Her<br>Important: if item<br>eny injury or othe<br>once.  |                | <ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service License</li> </ul>      |  |                               |  |  | 111,2008  |   |  |
| B                 | permit. I<br>Departm<br>Importar<br>eny inju   | Į.             | 1 1 1  | edesty MO119   |                               |  |  | dent cre  |   | over,MB 21676                                    |
|                   |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                               | lications that caused the death.   |                               | er the mode of dyin                          | g, such as cardiac                       | or respiratory arres                            | t,                                      | Approximate<br>Interval Between                  |
| 120               | Physician  |                | Immediate Cause (Final disease or condition  |  |                               |  | e ninana                                 | MAY DUE   | . /                                     | Onset and Death                                  |
|                   | /Medical   |                | resulting in death)  | Due to (or as a conseque   |                               | מנייייונני                                   | 1.00110                                  | MAN THE   | 1312                                    | 4171165  |
| г                 | Examiner   | L              | Sequentially list conditions,  | b  |                               |  |  |   |   |  |
|                   | bed √ isi  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury | Due to (or as a conseque   | ence of):                     |  |  |   |   |  |
| _,                | sician and burial-transit  | xar            | that initiated events<br>resulting in death) Last  | c<br>Due to (or as a conseque  | ence of):                     |  |  |   |   |  |
| 760               | le be executed<br>ysician and<br>e burial-transit  | cal            |  | d  |                               |  |  |   |   |  |
| 9                 |  |                |  |  |                               |  |  |   |   |  |
| Вох               | death certifica<br>e attending ph<br>ed for use as th  | an/N           | 230. Was decedent pregnant   | 23c. If yes, outcome of pregnant<br>1 ☐ Live birth 2 ☐ Fetal o   |                               | Ectopic pregnancy                            |  |   | 23d. Date of de                         | ,  |
|                   | de de  | Physician/Medi | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 4□Pregnant at time of dea<br>9□Unknown   |                               | Other (specify)                              |  |   | Month                                   | Day Year   |
| P.0               | t tac  | Phy            | Part II. Other significant conditions co   |  | tiaa ia Abaa                  | deal frances                                 | and the Broad I                          | 00a Didaaha                                     |   | - the second of death 2                          |
| ds,               | ires tha<br>signed<br>d be del   | by             |  |  |                               |  | эл ил Ралт I.                            |   |   | o the cause of death?                            |
| Ö                 | w requir<br>been si<br>should  | etec           | - CONDY AIN NO   | E lbenor 1   | Type                          | 113  |  |   |   |  |
| Rec               | 0 4 9  | Completed      | PEMENT   | 1A   |                               |  |  | 24a. Was an autopsy performe                    | prior to                                | utopsy findings available completion of cause of |
| ā                 |  | e Co           | 25. Was case referred to medical   |  |                               |  |  | 1 ☐ Yes 2                                       | No 1 ☐ Yes                              | 2 1 No   |
| of Vital Records, |  | To Be          | examiner?  | Hospital: 1 ☐ Inpatient 2 ☐ E  | P/Outpation                   | 2CI DOA Oth                                  |  | th (Check only one) ome 5 \subsetence Residence | 5 TOther (0-                            |  |
|                   | g Phys<br>er this<br>ieral di  | n: T           | 27. Manner of Death  | 28a. Date of Injury 2  | 8b. Time of                   | 28c. Injun<br>Worl                           |  | 28d. Describe how                               | _                                       | эспу)  |
| 0                 | Attending r death. ector: After by the fune  | atlo           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)  | Injury                        |  | Yes 2□No                                 |   |   |  |
| Division          | I or Attendater death<br>Director:<br>I in by the  | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At hom<br>building, etc. (Specify)  | e, farm, stre                 | et, factory, office                          |  | 28f. Location (Stree<br>City or Town,           | et and Number or R                      | ural Route Number,                               |
|                   | itel or<br>urs afte<br>rel Dire  |                |  |  |                               |  |  |   |   |  |
|                   | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | edical         | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami   | sician: To the best of my knowliner: On the basis of examination   | ledge, death<br>on and/or inv | occurred at the tine<br>estigation, in my of | ne, date and place<br>pinion, death occu | and due to the cau-<br>rred at the time, date   | se(s) and manner a<br>and place, and du | s stated.<br>e to the cause(s)                   |
|                   | To the within 2 To the complet   | Mec            | 29b. Signature and title of certifier  | and manner stated.   |                               | 29c. License                                 | number                                   | 29d   | . Date signed (Mon                      | th. Dav. Year)                                   |
|                   | ⊢ ≯ ⊢ ŏ  |                | 1 41.  | 1//  | -                             | 0  | 111-                                     |   | •                                       |  |
|                   | . 1  |                | 30. Name and address of poison who ca  | ompleted cause of death (Item 2  | 23a) (Type, F                 | Print)                                       | 14/                                      |   | PRIL (0                                 | 12008  |
|                   | 11   |                | Extern Arryon  |  |                               |  | PRIVATE                                  | i mm  | 41019                                   |  |
|                   | Sta  | 417            | 31. Date filed (Month, Day, Year)<br>APR 1 4 2008  | 32. Registrar's Signatu  | ге                            | ,  |  |   |   |  |
|                   | Registr  | ar             | AFR 1 4 2000   | AND STATE OF SERVICE STATE STATE OF SERVICE STATE STATE STATE STATE OF SERVICE STATE | S. T. San San                 |  |  |   |   |  |

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136ER,

| -02810<br>illiam Albert Kil   | 1-             | S<br>For State  | <b>pe or Print in B</b><br>tate of Maryland           | / Depai               | rtment       | Ink. Ensure<br>of Health are<br>of Death     | re All Co<br>nd Menta             | <b>pies Ar</b><br>Il Hygien     | e Legible<br>e<br>Reg. No       | 20  | 108 1199                                      |  |
|---|----------------|---|---|-----------------------|--------------|--|-----------------------------------|---------------------------------|---------------------------------|---|---|--|
| Physicia  |                | egistrar<br>. Decedent's Name (First, Mid   | dle,Last)   |                       |              |  |                                   | Mon                             | of Death                        | Year  | 3. Time of Death                              |  |
| edical Examin   | ner            | William Alber   |   |                       |              |  |                                   |                                 | 10, 2008                        | c. County of Dea                              |   |  |
| 1 14  |                | la. Facility Name (if not institut<br>903 Sue Grove Road  |   | r)                    |              | 4b. City, Town, o                            | or Location of                    |                                 |                                 | Baltimore County                              |   |  |
| Funeral   |                | 5. Social Security Number   | 6. Sex 7. A   | ge (In yrs. la        | st birthday) | If Under 1 Ye                                |                                   | 24Hrs. 8. Da<br>Min.            | te of Birth(MM                  | h(MM/DD/YYYY) 9. Birthplace (State or Foreign |   |  |
| Director  | L              | 220-24-0423   | 1X M 2 F  | 7                     | 8            | Months Da                                    | lys Hours                         | 12                              | 2/16/19                         | 29  | Country) Maryland                             |  |
| v any   | Ī              | Usual Residence of Decedent<br>10a. State 10b. Count  | у   | 10c. City,            | Town or Lo   | cation                                       |                                   | -                               |                                 |   | 10d. Inside City Limits  1 Yes 2 X No         |  |
| and<br>f show   | 5              |   | imore   | Ess                   | sex_         | 10f, Zip Code                                |                                   |                                 | 10g. C                          | tizen of What C                               | ountry?                                       |  |
| Mary<br>28a-  | 인              | 10e. Street and Number  |   |                       |              | · ·  |                                   |                                 | II S                            | S.A.  |   |  |
| th the  |                | 003 Sue Grove   | Road<br>12. Was Decede                                | nt Ever in II         | s 13         | 21 22<br>Was Decedent of I                   | Hispanic Origi                    | n? (Specify Y                   | es or No-                       |   | nencan Indian, Black,                         |  |
| ith will tems st be   | ₩ I            | 11. Marital Status  1 Never Married 2 X   | Married Armed Force                                   | s?                    | 0.   10.     | If Yes, specify Cub                          | an, Mexican,                      | Puerto Rican,                   | etc.)                           | White, etc                                    | <b>.</b> .                                    |  |
| er dez  | Fu             |   | 1 X Yes<br>Divorced If Yes, Give Year 1               | 2 No 944_1            | 950 1        | Yes 2xx                                      | No specify:                       |                                 |                                 |   | hite  |  |
| urs aft   | 휘              | 15. Decedent's Education (S   |   |                       | 16a Dece     | dent's Usual Occu<br>g most of working l     | pation (Give k                    | ind of work do                  | ne 16b                          | . Kind of Busine                              | ss/Industry                                   |  |
| 2 hou   | ompleted       | Elementary/Secondary (0-1:  |   |                       |              |  | ile. Do No i                      | ise retired)                    |                                 | l a mt mil a                                  |   |  |
| 036<br>thin 7   | du             |   | 4   |                       | Elec         | ctrician                                     | T-2-1-1                           | N (E)                           | Middle, Maide                   | Lectric                                       |   |  |
| 5-0(<br>ed wi<br>tygies<br>other  | ပ              | 17. Father's Name (First, Midd  |   |                       |              |  |                                   |                                 | na Wise                         |   | <del>unk.</del>                               |  |
| 21;<br>be fill<br>sutal F<br>rrked<br>vent,   | ш.             | Villiam Albert  |   |                       | 10h M        | illing Address (St                           |                                   |                                 |                                 |   |   |  |
| D 21<br>hould<br>nd Me<br>is ma   |                | 19a. Informant's Name/Relation  |   |                       |              | 07 Mt. Zi                                    |                                   |                                 |                                 |   |   |  |
| ME 2 SI alth an m 27  |                | Karen Diehl (D  | augnter)  | 20h                   | Place of Di  | sposition (Name of                           | cemetery,                         | Date                            | 20                              | c. Location - City                            | y or Town, State                              |  |
| s 1 an of Hea   | l f            | 20a. Method of Disposition  1 Burial 2 X Cremat   | tion 3 Removal from                                   | State                 | crematory o  | r other place)                               |                                   | 04/14/                          | 2000 B                          | al+imor                                       | e, Maryland                                   |  |
| Page<br>nent c  |                | 4 Donation 5 Other  | Specify:  | Ba                    |              | Cremator                                     | - ( = -1114 -                     |                                 |                                 |   |   |  |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland begattment of Health and Mental Hygiene. Important: I friem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.   |                | 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221  |   |                       |              |  |                                   |                                 |                                 |   |   |  |
| (   |                | 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate interval. |   |                       |              |  |                                   |                                 |                                 |   |   |  |
| Physician<br>Medical<br>caminer   | ľ              | failure. List only one cau<br>immediate Cause (Final disea<br>or condition resulting in death   | use on each line.<br><sub>ase a.</sub> Intraoral Guns | shot Wou              | nd           |  |                                   |                                 |                                 |   | Death   |  |
|   | Examiner       | Sequentially list conditions, if any, leading to immediate the Underlying Car (Disease or injury that initiate  | d C.  |                       |              |  |                                   |                                 |                                 |   |   |  |
| ecuted and transit  |                | V.  |   |                       |              |  |                                   |                                 |                                 |   |   |  |
|   |                | UNPENDED  | X AMENDED   | 18 per                | fh g         | 878 4-24                                     | -08 vt                            |                                 |                                 |   |   |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | sician/Medic   | IF FEMALE:<br>23b. Was decedent pregnant<br>past 12 months?   | 4 Pregnan   | n<br>at at time of d  | 2            | Fetal death Other (Specify)                  | 3 Ectopie                         | c pregnancy                     |                                 | 23d. Date of de<br>Month                      | livery<br>Day Year                            |  |
| O. Bc<br>at the dez<br>1 by the z   | Phy            | Part II. Other significant co   | 9 OIKHOW  |                       | resulting in | the underlying cau                           | use given in Pa                   | art I.                          |                                 |   | te to the cause of death?  Probably 4 Unknown |  |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the staffer death.  In Director: Affect this certificate has been signed by led in by the funeral director, page 2 should be detach  | ed by          |   |   |                       |              |  |                                   |                                 | 24a. Was an                     | 1 24b. We                                     | re autopsy findings available                 |  |
| ord<br>w rec<br>as bee  | <u>B</u>       |   |   |                       |              |  |                                   | <del></del>                     | autopsy<br>performe             | d? dea  | or to completion of cause of ath?             |  |
| Rec<br>The Iz<br>cate h   | Completed      |   |   |                       |              |  |                                   | (8)                             | Yes 2                           | No 1  | Yes 2 No                                      |  |
| al Fian: 'ant: 'ertific   | Be C           | 25. Was case referred to me examiner?   |   |                       |              |  | Other                             | Nursing Ho                      |                                 | sidence 6                                     | Other: Scene                                  |  |
| Vit<br>hysici<br>this o   | 일              | 1 ✓ Yes 2 No  |   | patient 2             |              | atient 3 DOA                                 | . Injury at Wor                   |                                 |                                 | v injury occurred                             |   |  |
| Of<br>ing P   | ١              | 27. Manner of Death   | 28a. Date of FOUND:                                   | r Injury<br>Day,Year) | FOUN         | ,,   | Yes 2                             | - ISut                          | ject shot s                     |   |   |  |
| ion<br>itend<br>leath.<br>for:  | ati            |   | Apr 10, 20  | 308                   | 1059 h       | rs   |                                   | ~ 1                             | Location (Stre                  | et and Number                                 | or Rural Route Number, Cit                    |  |
| ViS<br>or At<br>Orrec<br>Direc  | ]<br>i         | 3 Suicide 6   | Could not be  |                       |              | , street, factory, of                        | nce building, e                   |                                 | or Town State                   |   |   |  |
| Dipital ours a neral I  | Certification: | 1 4 Homicide  |   | Single Fa             |              |  |                                   |                                 |                                 |   |   |  |
| 24 hr<br>24 hr<br>Fun   | ia             | 29a. Certifier 1 Certifyir  | ng Physician: To the best<br>Examiner:On the basis of | of my knowle          | edge, death  | occurred at the time<br>estigation, in my or | ne, date and p<br>pinion, death o | iace, and due<br>ccurred at the | to the cause(s<br>time, date an | d place, and due                              | e to the cause(s)                             |  |
| To the<br>within<br>To the  | Medical        |   | and manner sta  | ited.                 | Singrot IIIV |  | icense numbe                      |                                 |                                 |   | (Month, Day, Year)                            |  |
| ->  | Įž             | 29b. Signature and title of ce  | ertifier  | 1                     |              |  | o.C.M.E.                          |                                 |                                 | April 11, 200                                 | •   |  |
|   |                | ahr   | m/  |                       | 7.5          |  | VI.L.                             |                                 |                                 |   |   |  |
| 10x1  | d              | 30. Name and address of pe  |   | of death (Ite         | em 23a)      | Penn Street,                                 | Raltimore                         | MD 21201                        |                                 |   |   |  |
| 10,   | 1              | Zabiullah Ali, M.D.   |   |                       |              | Penn Street,                                 | Daminore,                         | 1110 2 120                      |                                 |   |   |  |
|   | ┸.             | 31. Date filed (Month, Day, Y   |   | istrar's Sign         | atuste.      | Canada Balla 2                               |                                   |                                 |                                 |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 25,27,28a-f per me, 8/8,04/14/08dhb

Rea. No. 3. Time of Death 2. Date of Death Month 4 **Physician** DB ΑM 1050 Raymond Kremzner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner university of Maryland Medical Center Bultimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 54 4-11-1953 Maryland Director 148-48-1683 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt. If Item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director MD Baltimore Co. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 202 6902 Bonnie Ridge Drive Apt. 21209 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shari Baskin - Friend 1 Hammil Court Apt 37 Baltimore, MD 21210 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any injury or o once. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Bayview Crematory 4-10-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 corouse omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the lise shock, or he fail (e. Physician seppos disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** FORTON APPROVED BY MEDICAL ENVINEER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnance Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9□Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an cate has I page 2 s autopsy performed? /es 2 1 No this certificate 1∐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ Division or funeral 28c. Injury at Work? 28d. Describe how injury occurred **Subject driver of a motorcycle** 28b. Time of 27. Manner of Death 28a. Date of Injury After Certification: 1 Natural 2 Accident 5 Pending investigation 10:08 a<sub>™</sub> 08/14/2007 1 TYes 2 No within 24 hours after oean...

To the Funeral Director: A collided with a minivan. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Ralls Road at Showmaker Rd., Bare Hills, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

(6)

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23aPt 1,11, 25 per me g8,78,04/11,08dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Douglas Corriston Keller 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** more HOSD If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 M 2 □ F 212-48-9446 61 8-11-1946 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Parkville Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 1708 Kennoway Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★) Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 27215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Computer Programmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren Leroy Keller Arline Reeder McNabb ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 Kennoway Rd., Parkville, MD 21234 19a. Informant's Name/Relationship (Type. Print)
Patricia Keller/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-12-2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition & rehagic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 9 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DATION TO NED BY MEDICIN EXAMINER that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 XYes 1 Inpatient Certification: To After this 27. Monner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation within 24 hours arter users.

To the Funeral Director: After an additional and a full filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D0042083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samarita

DHMH 17 Rev 1/2001

State

Registrar

A. Whee

APR 1 4 2008

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician 2115 M /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN 6. Sex 10 M 2 F Date of Birth Month Day Year 03/02/1921 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-01-6633 87 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be natified at 1 ☐ Yes 2 No Director BALTIMORE PIKESVILLE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE, APT. 111 21208 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No ≥ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER LUMBER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ABRAHAM** KAHN Sarah SOLOMON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SLADE AVENUE, APT. 111, PIKESVILLE, MD ESTELLE KAHN / WIFE 20b. Place of Disposition (Name of cemeters cramators of place of AUSHE EMUNAH ATTZ CHAIM 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/11/2008 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Due to (of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine g physician and The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending p for use as IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? has certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 | No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Y April 11, 2008 Ann Liebenstein 6:20a<sup>M</sup> 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Timonium Baltimore Stella Maris Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/19/1957 5. Social Security Number 390–62–3138 6. Sex 7. Age (In yrs. last birthday) 50 Days 1 ☐ M 2 🖫 F WI Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Sparrows Point Baltimore 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7312 Waldman Avenue 21219 USA Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ School of Medicine Program Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bert Liebenstein Audrey Erlwig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 288 Bley Parkway, Port Washington, WI 53074 Audrey Liebenstein / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 04/17/2008 Port Washington, WI Union Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. Fort Avenue, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) etasta Weeks Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a. Was an autopsy performed? res 2. No 1□ Yes 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Director

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Completed

Be

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healith and Mental Hygiene. Department of Healith and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

neral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran P.O. Box 68760, or Vital Records. Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

LIEBENSTEIN,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🔀 Natural 1 ∏Yes 2 ∏No М 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Mestine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

ERNESTINE WRIGHT, M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM MD 21093

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier